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# THE DOCTRINE OF INFORMED CONSENT: TO INFORM OR NOT TO INFORM?

PAULA WALTER\*

Two decades have passed since the New York Legislature enacted the Medical Malpractice Act (the "Act").<sup>1</sup> In a climate of controversy within the medical and legal communities,<sup>2</sup> the Act provided a statutory basis for a lack of informed consent claim, established standards for disclosure of information to patients by physicians, and set parameters within which medical providers must obtain *informed* consent. Over the years, much scholarly effort has been directed at determining when and why the transformation from the common law requirement of "consent" to "informed consent" occurred.<sup>3</sup> Academic discussion has also fo-

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<sup>1</sup> Effective in 1975, the New York Legislature enacted Chapter 109, entitled "Medical Malpractice." This statute was added to the Public Health Law as section 2805-d, which is entitled "Limitation of medical malpractice action based on lack of informed consent."

<sup>2</sup> For a discussion of the environment in which the Act was passed, see Peter V. Coffey, *Assault on Informed Consent*, 48 N.Y. ST. B.J. 447 (1976). In an article written for practitioners, the author opines that the legislation was enacted "in a state of near hysteria over the rising cost of medical malpractice insurance and its assumed consequences [and] virtually abolish[es] the patient's right to receive information in advance of surgery." *Id.* at 447. Coffey further states:

It is the opinion of this writer, therefore, that although the 1975 legislation labeled the action 'medical malpractice' and although the action is substantially altered, it remains an action based upon trespass or assault and not upon negligence. The decisions of the courts of this state in interpreting the new legislation will rest largely upon whether the courts adhere rigidly to their former approach or whether they 'base their judgments upon broad considerations of policy' as set forth in the legislative principles enunciated in Chapter 109.

*Id.* at 479.

<sup>3</sup> The passage of the New York statute was seen by many commentators as a necessary reaction to a trend in the development of case law that had become overly consumer friendly and exceedingly plaintiff oriented. See Stephen Zuckerman et al.,

cused on whether the cause of action for a failure to obtain informed consent is grounded in contract law,<sup>4</sup> fiduciary law,<sup>5</sup> negligence or intentional tort law.<sup>6</sup> Since the enactment of the Act in 1975, these discussions have been muted in New York State, but language in cases subsequent to its passage still harks back to that earlier controversy.

With the advantage of hindsight provided by a twenty year time prism, together with a significant number of appellate-level

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*Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 85, 91-94 (1986) (discussing increases in claims and award amounts during 1970's). Still, others believe that the medical malpractice statute was passed in order to thwart what was seen as a trend towards strict liability in medical malpractice litigation. See, e.g., Ronald K. Fierstein, Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 BROOK. L. REV. 241, 242-43 (1978) (discussing then current trend of imposing liability upon medical community for non-negligently causing harm). To others, the enactment of the statute was seen as the legislature's effort to abolish the patient's right to receive information. See Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 141 (1977) [hereinafter *Law's Vision*] (arguing that principle of self-determination is given little mindfulness because judges, who do not inquire into physician-patient dialogue or into quality of consent, are ambivalent towards patients' right to individual choice).

<sup>4</sup> Although the doctor-patient relationship is based on the patient's purchase of the physician's services, these services were always viewed as distinct from ordinary commercial services. See P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287, 292 (1986). A medical malpractice claim is a claim for recovery of damages for injuries sustained as a result of a medical treatment. Issues relating to the nature of the physician-patient relationship involve questions of foreseeable risk and unforeseeable accidents. These questions have engendered debate as to whether this relationship is or should be governed by contract law or tort law. See generally Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 LAW & CONTEMP. PROBS. 201 (1986) (suggesting tort doctrine embracing informed consent requirements should allow doctors and patients to alter prescribed regulations by private agreement); Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87, 91-96 (1976) (opining that consensual relationships such as that between doctor and patient should be governed by contract law); A.J. Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U. L.Q. 413, 435 (1953) ("The history of malpractice actions shows the theories of tort and breach of implied contract to be inextricably bound up together.").

<sup>5</sup> See Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879, 892-902 (1988) (recognizing situation-specific motions of fiduciary obligations); Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 802 (1983) (observing reliance on fiduciary law as replacement for weakened social controls); Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 367 (1990) ("The patient's need for information ... triggers the operation of fiduciary rules.").

<sup>6</sup> See generally Peter A. Bell, *Legislative Intrusions Into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939 (1984).

decisions, a retrospective of what has transpired in this area is proper. Appropriately, this article will examine the case law in the field of informed consent in order to analyze the ultimate effects of the Act and to determine whether any markers or guideposts for both physicians and patients have been created by this statutory map. In this context, this article will determine whether the statute has weaved a path of accommodation between doctor and patient or whether medical paternalism continues, and whether the legislation has been consumer friendly.

This article, in Part I, will begin by analyzing the philosophical underpinnings upon which the legal assumptions of the doctrine of informed consent are predicated. Part II will examine the provisions of the statute, while Part III will scrutinize the case law interpretation of the legislation. Finally, Part IV concludes with an examination of the postulates yielded by cases in the area of informed consent.

## I. PRINCIPLES UNDERLYING THE DOCTRINE OF INFORMED CONSENT

The concept of self-determination, which assures that man is master of his destiny, is deeply rooted in our legal system and is the legal mirror of the Western values system, which exalts the individual.<sup>7</sup> Judge Benjamin Cardozo expounded the concept of self-determination in *Schloendorff v. New York Hospital*<sup>8</sup> by noting that "[e]very human being of adult years and sound mind has a right to determine what shall be done to his body."<sup>9</sup> Based on this statement of principle, judicial decisions have spawned the legal principles of consent, which eventually developed into the doctrine of informed consent.<sup>10</sup> The doctrine has evolved to

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<sup>7</sup> See *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960) ("Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body ...."). Recent examples of the recognition of the principle of self-determination are expressed in abortion and right-to-die cases. The Supreme Court has interpreted the liberty interest as embracing the ideas of physical freedom and self-determination. See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 288 (1990) (O'Connor, J., concurring) (citations omitted) ("[F]orced treatment may burden [an] individual's liberty interest[] as much as any state coercion.") (citations omitted).

<sup>8</sup> 211 N.Y. 125 (1914), *overruled in part by* *Bing v. Thunig*, 2 N.Y.2d 656 (1957).

<sup>9</sup> *Id.* at 129.

<sup>10</sup> Patients have been required to give consent to medical treatment since 1880. See *State v. Housekeeper*, 16 A. 382, 384 (Md. 1889) (noting that surgeon is justified in performing operation with consent of patient). Early cases held that an unauthor-

reflect strong judicial deference for individual autonomy—that is, the belief that an individual has the right to be free from non-consensual interference with his or her person.<sup>11</sup> This fundamental principle of autonomy incorporates the notion that a person has the right to control his or her choice.<sup>12</sup> In the medical context, the concept of autonomy translates into an understanding that the individual has an unfettered right to choose the course of medical treatment, including the right not to pursue treatment and to desist from any treatment where such medical protocol has already been initiated.<sup>13</sup> By corollary, this precept implies that the decision of the patient will be respected.

At the same time that the medical provider must respect the autonomy of the patient, the Hippocratic Oath<sup>14</sup> and the physi-

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ized treatment was a battery committed upon the patient. Negligence has now generally replaced battery as the basis for liability in medical malpractice cases. See *Scott v. Bradford*, 606 P.2d 554, 557 (Okla. 1979) ("If treatment is completely unauthorized and performed without any consent at all, there has been a battery. However, if a physician obtains a patient's consent but has breached his duty to inform, the patient has a cause of action sounding in negligence ...."). The idea that physicians are obligated to seek assistance in the decision-making process evolved further in the 1960's. See *Natanson*, 350 P.2d at 1103 (noting that physician who fails to reveal likely consequences of treatment may be subjected to claim of unauthorized treatment). The *Natanson* court held that the basis of liability was "the deviation from the standard of conduct of a reasonable and prudent medical doctor of the same school of practice as the defendant under similar circumstances." *Id.* at 1107.

<sup>11</sup> See *Cruzan*, 497 U.S. at 269 (citing *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person from all restraint or interference of others, unless by clear and unquestionable authority of law.")).

<sup>12</sup> The principle of autonomy emanates from the penumbras of the Bill of Rights. See *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) ("These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."). The Supreme Court's decisions have demarcated a "private realm of family life which the state cannot enter." *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944). The liberty to make choices concerning one's private life is fundamental to our "concept of ordered liberty." *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), *overruled by* *Benton v. Maryland*, 395 U.S. 784 (1969). Furthermore, the Court has recognized that the relationship between doctor and patient is often encompassed within the domain of private life protected by the Due Process Clause. See *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965).

<sup>13</sup> Competent individuals have a constitutionally protected liberty interest in refusing unwanted medical treatment. See, e.g., *Cruzan*, 497 U.S. at 284 (recognizing right to terminate life-sustaining hydration and nutrition treatment). The right to refuse medical treatment is guaranteed by the Fourteenth Amendment of the United States Constitution, which states: "[No] State shall deprive any person of life, liberty, or property, without due process of law." U.S. CONST. amend. XIV.

<sup>14</sup> The Hippocratic Oath is the statement: "I swear by Apollo and Aesculepius

cian's training obligate the physician to provide medical care to those who seek his services. Specifically, the medical provider is guided by the principle of beneficence, which dictates that the physician actually contribute to the patient's health rather than merely avoid harm.<sup>15</sup> The principle of beneficence competes with the principle of autonomy by requiring the physician to use his training to decide the best treatment of his patient, who may in fact prefer a different medical treatment. In an ideal setting, these two competing values do not collide. In reality, however, the principles of autonomy and beneficence do collide.<sup>16</sup> As a result, problems arise in allocating authority for treatment between the physician and the patient.

The doctrine of informed consent was developed to accommodate these tensions. The doctrine imposes two independent duties on the medical provider: first, the medical practitioner has a duty to disclose information; and second, the practitioner has an obligation to obtain an informed consent from the patient.<sup>17</sup> In order to grant an informed consent, the patient (1) must be competent, (2) must understand the information conveyed, and (3) must voluntarily give his consent free from coercion.<sup>18</sup> The informed consent doctrine envisages a joint decision-making process in which the physician digests the technical information for

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that I will follow that system of regimen which according to my ability and judgment I consider for the benefit of my patients ...." Jay Katz, *Informed Consent—Must it Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 73 (1994) [hereinafter *Fairy Tale*].

<sup>15</sup> The principle of beneficence imposes "the duty to help others further their important and legitimate interests ... to confer benefits and actively to prevent and remove harms ... and to balance possible goods against the possible harms of an action." *Fairy Tale*, *supra* note 14, at 83 (citing THOMAS L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS*, 148-49 (2d ed. 1983)).

<sup>16</sup> For an excellent discussion on the interplay between the two principles of autonomy and beneficence, see *Law's Vision*, *supra* note 3; *Fairy Tale*, *supra* note 14; Jon F. Merz, *On a Decision-Making Paradigm of Medical Informed Consent*, 14 J. LEGAL MED. 231 (1993); Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749 (1986).

<sup>17</sup> See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 1993).

<sup>18</sup> Some commentators question the very premise upon which the informed consent doctrine is predicated and argue that the law disregards or remains unaware of the cognitive limitations on both the practitioner and the patient. See, e.g., J.F. Merz & B. Fischhoff, *Informed Consent Does Not Mean Rational Consent, Cognitive Limitations on Decision-Making*, 11 J. LEGAL MED. 321, 340 (1990); see also Bruce J. Winick, *Competency To Consent To Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 16 (1991) (noting that elements of informed consent include "disclosure of information, competency, understanding, voluntariness, and decision making").

the patient and transmits this information in a manner comprehensible by a layperson.<sup>19</sup> The patient, in turn, asks questions, evaluates the information conveyed, and agrees to either proceed or not to proceed with the recommended treatment.

Although the role of the physician as a professional with the ability to understand such technical information is clearly within the purview of the doctrine, an issue remains as to whether the doctrine considers the patient's cognitive abilities. A related question is whether the doctrine merely seeks to assess the patient's ability to understand rather than attempting to examine the patient's actual understanding of the medical issues.<sup>20</sup> Many physicians are skeptical that the patient can even begin to understand the technical intricacies of a medical diagnosis and its concomitant protocols of treatment. In New York, the Act assumes that the patient is competent and that his decisions are not subject to pressure.<sup>21</sup> In certain circumstances, however, the patient may feel frightened and confused, and consequently he may focus his resources entirely on the physician selection process and may ultimately defer further medical decisions to the physician.<sup>22</sup> In this instance, medical providers are perceived by

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<sup>19</sup> Even cases that are most supportive of the plaintiff have stated "[f]irst, the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications [and a] mini-course in medical science is not required ...." *Cobbs v. Grant*, 502 P.2d 1, 11 (Cal. 1972).

<sup>20</sup> The inequality of the physician-patient relationship stems from the physician's superior knowledge of medicine and the patient's need for care. See Marjorie M. Shultz, *From Informed Consent to Patient's Choice: A New Protected Interest*, 95 YALE L.J. 219, 221-22 (1985) (discussing how patient's lack of technical ability to make medical decisions and expertise of doctors are justifications for doctors' preempting patient's authority). The doctrine of informed consent seeks to minimize the inequality in this relationship. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972); *Salgo v. Leland Stanford Univ.*, 317 P.2d 170 (Cal. 1957); *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).

If the function of the informed consent doctrine is to protect a patient's right to make a "personal decision," then there must be safeguards to assure that doctors are providing adequate information. If, however, the goal is to ensure "rational" decisions, then a patient's level of understanding becomes critical. See Alan Meisel, *The Expansion of Liability For Medical Accidents: From Negligence to Strict Liability By Way of Informed Consent*, 56 NEB. L. REV. 51, 117-21 (1977).

<sup>21</sup> Section 2805-d speaks of a "knowledgeable" or a "reasonably prudent person." § 2805-d(1), (3). Thus, the notion of an incompetent person is not encompassed within this provision.

<sup>22</sup> See, e.g., *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 442 (Cal. 1963) (involving patient who was in pain, sedated, and unable to comprehend hospital's waiver form).

some to bear an inherent conflict of interest, especially in a system that remunerates the provider on a fee-for-service basis.<sup>23</sup>

Since a physician is trained to enhance the patient's health, it appears that he will usually seek to achieve that goal. With such an obligation, how can the physician agree with the competent patient's rational decision to refuse treatment? Can the physician be required to concur with the patient when their respective expectations for treatment, including non-treatment, collide? To what extent will the doctrine of informed consent mandate the medical practitioner to respect the autonomous choices or acts of his patients? The New York Legislature attempted to resolve these questions by providing for a statutory mandate of informed consent. Section 2805-d of the New York Public Health Law defines the contours of the informed consent doctrine.

## II. NEW YORK PUBLIC HEALTH LAW § 2805-d

In 1975, the New York Legislature enacted the Medical Malpractice Act in an attempt to simplify the existing common law doctrine of informed consent.<sup>24</sup> This Act sets forth a statutory cause of action that is separate and distinct from medical malpractice<sup>25</sup> for patients injured in a non-emergency medical procedure for which the medical provider failed to obtain informed consent.

### A. "Informed Consent" Defined

Lack of informed consent is defined in section 2805-d(1) as: the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.<sup>26</sup>

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<sup>23</sup> See Theodore J. Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124, 164 (1976) (noting that economic pressures may alter physician's disclosure).

<sup>24</sup> See *Williams v. Cordice*, 418 N.Y.S.2d 995, 997 (Sup. Ct. 1979) (reviewing pre-statutory confusion as to legal basis of cause of action for lack of informed consent).

<sup>25</sup> See *Pan v. Coburn*, 463 N.Y.S.2d 223 (App. Div. 1983); *Bellier v. Bazan*, 478 N.Y.S.2d 562 (Sup. Ct. 1984); *Pagan v. State*, 476 N.Y.S.2d 468 (Ct. Cl. 1984).

<sup>26</sup> N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 1993).



The Legislature has outlined the elements of an informed consent that must be satisfied in order to form an unassailable consent. This language mandates that the provider is not required to provide full disclosure of all alternatives and risks.<sup>27</sup> The onus is placed on the medical provider to disclose only the alternatives of the suggested treatment or diagnosis and its "reasonably foreseeable risks and benefits." As Part III of this Article will demonstrate, case law assists in deciphering which risks are "foreseeable" and therefore subject to disclosure under the statute.<sup>28</sup>

The treating physician does not decide which risks are material enough to disclose but rather, the scope of the disclosure is governed by what a reasonable practitioner "under similar circumstances would have disclosed." This objective standard requires expert testimony concerning the degree and quality of information that the particular medical provider should have provided to his patient under the circumstances.<sup>29</sup> The standard of the medical community is determinative of the scope of materiality for disclosure.

Similarly, the reasonableness of the disclosure is not judged by whether the patient himself actually understood the alternatives and risks as explained to him. However, in order to mitigate the severity of the objective standard, the New York Legislature introduced the qualifying requirement that the information transmitted to the patient be made "in a manner permitting the patient to make a knowledgeable evaluation." Hence, in cases where a reasonably prudent physician in similar circumstances would not have given the patient information other than that which the particular physician provided, the

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<sup>27</sup> See *Chapman v. State*, 468 N.Y.S.2d 792, 792 (App. Div. 1983) (finding no need for physician to discuss alternative procedures if they would not be productive); *Troy v. Long Island Jewish-Hillside Med. Ctr.*, 446 N.Y.S.2d 347, 349-50 (App. Div. 1982) (finding error in trial court's charge to jury that doctor must describe "all" available options).

<sup>28</sup> See *infra* Part III.

<sup>29</sup> See *Koller v. Manhattan Eye, Ear & Throat Hosp.*, 563 N.Y.S.2d 497, 498-99 (App. Div. 1990) (finding that section 2805-d(1) is satisfied by medical testimony showing that proper informed consent would have required doctor to advise patient of risk of double vision resulting from surgery); *Gonzalez v. Moscarella*, 530 N.Y.S.2d 218, 219 (App. Div. 1988) (requiring expert medical testimony to support qualitative sufficiency of disclosure); see also N.Y. C.P.L.R. 4401-a (McKinney 1993) (providing for summary judgment for failure to produce expert testimony as to qualitative sufficiency of disclosure).

physician must convey the information in a manner that will allow the patient to make a knowledgeable evaluation.<sup>30</sup> It appears that the legislature understood that removing patient input *in toto* would emasculate the notion of informed consent. In essence, under the statute, the entire process—the give and take between doctor and patient—is examined.<sup>31</sup> It is in this manner that the statute strikes a balance between the two competing values of self-determination and beneficence.

### B. *Limitations on the Duty to Disclose*

In section 2805-d(2), the legislature grants a cause of action for malpractice based on lack of informed consent in cases involving either “non-emergency treatment, procedure or surgery” or procedures that involve “invasion or disruption of the integrity of the body.”<sup>32</sup> With the benefit of an earlier New York case, *Sullivan v. Montgomery*,<sup>33</sup> the term “emergency” has been understood to include both the endangerment of life or health and the need for alleviation of pain.<sup>34</sup>

The second-half of section 2805-d(2) is of particular import. Therein, the legislature clarified that a cause of action can lie where the procedure “involved invasion or disruption of the integrity of the body.” Accordingly, section 2805-d(2) has shut the

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<sup>30</sup> See *Nisenholtz v. Mount Sinai Hosp.*, 483 N.Y.S.2d 568, 571-72 (Sup. Ct. 1984) (requiring that description of potential complications be detailed enough so reasonably prudent patient can assess chances of harm and decide whether to give his consent).

<sup>31</sup> See generally *Dries v. Gregor*, 424 N.Y.S.2d 561 (App. Div. 1980) (noting that focus must be on doctor's duty to communicate with patient); *Zelevnik v. Jewish Chronic Disease Hosp.*, 366 N.Y.S.2d 163 (App. Div. 1975) (stating that doctrine of informed consent is based upon patient's right to control his body and such right is not at sole disposal of medical community).

<sup>32</sup> N.Y. PUB. HEALTH LAW § 2805-d(2) (McKinney 1993). Section 2805-d(2) states that “[t]he right of action to recover for medical, dental or podiatric malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body.”

<sup>33</sup> 279 N.Y.S. 575 (City Ct. 1935).

<sup>34</sup> See *id.* at 577. The rationale of the *Sullivan* court is as follows:

To hold that a physician or surgeon must wait until perhaps he may be able to secure the consent of the parents, who may not be available, before administering an anesthetic or giving to the person injured the benefit of his skill and learning, to the end that pain and suffering may be alleviated, may result in the loss of many lives and pain and suffering which might otherwise be prevented.

*Id.* at 577.

door to any claim advanced by a plaintiff who seeks compensation for a non-physical injury. Now, in order to make out a *prima facie* case in negligence, the plaintiff-patient must adduce evidence of an actual injury.<sup>35</sup> Consequently, claims brought to rectify an insult to a person's dignity are not permitted if couched in malpractice terms because the statute will not permit redress for such injuries in the absence of a physical harm.<sup>36</sup> This is an important distinction which is derived from earlier cases that clarified the difference between negligence and battery causes of action.<sup>37</sup>

In those earlier cases, a physician who simply touched a patient without first obtaining the patient's consent was guilty of battery and the patient could recover against that medical provider.<sup>38</sup> The tort of battery is completed at the moment of the nonconsensual touching.<sup>39</sup> Whether the plaintiff is appropriately treated by such touching or whether the patient's welfare is actually enhanced are irrelevant questions.<sup>40</sup> The affront is to the person's dignity because his consent was not voluntarily given.<sup>41</sup> In such cases, the courts were addressing this outrage to the pa-

<sup>35</sup> See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984) (reviewing elements of cause of action in negligence).

<sup>36</sup> See *Bernard v. Block*, 575 N.Y.S.2d 506, 511 (App. Div. 1991) (holding that lack of informed consent claim requires plaintiff to prove that treatment was proximate cause of injury); *Flores v. Flushing Hosp. & Med. Ctr.*, 490 N.Y.S.2d 770, 772 (App. Div. 1985) ("It must be proven ... that the plaintiff in fact suffered an injury which medically was caused by the treatment.").

<sup>37</sup> See *infra* Part IIIa (discussing medical malpractice action and whether this cause of action is rooted in common law battery or negligence); see also *Mohr v. Williams*, 104 N.W. 12, 14 (Minn. 1905) (expressing right to inviolability of the person as "necessarily forbid[ding] a physician or surgeon, however skillful or eminent, who has been asked to examine, diagnose, advise and prescribe ... to violate, without permission, the bodily integrity of his patient ....") (quoting *Pratt v. Davis*, 37 CHI. LEG. NEWS 213)).

<sup>38</sup> In *Schloendorff v. New York Hospital*, 211 N.Y. 125 (1914), Judge Cardozo held that "a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." *Id.* at 129-30; see also *Mohr*, 104 N.W. at 14 (stating that doctor who performed surgical operation without consent of patient can be held liable in civil action for assault and battery).

<sup>39</sup> Battery is defined as "[a] harmful or offensive contact with a person, resulting from an act intended to cause the plaintiff ... to suffer such a contact ...." W. PAGE KEETON, *supra* note 35, at 39 (emphasis added).

<sup>40</sup> If treatment was given without the informed consent of the patient, the medical provider is liable no matter how skillfully he administered the treatment. See *Natanson v. Kline*, 350 P.2d 1093, 1107 (Kan. 1960).

<sup>41</sup> See generally *supra* note 10 (discussing development of informed consent doctrine).

tient's person.

### C. Causation

Once a plaintiff proves a lack of informed consent in a situation that does not fall within a statutory exception, he must further prove that such inadequate disclosure was both the actual and proximate cause of his injury. Section 2805-d(3) sets forth the causal requirements as follows:

For a cause of action therefor [sic] it must also be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought.<sup>42</sup>

Hence, New York imposes a two-fold burden on the plaintiff-patient. First, the plaintiff must adduce evidence that a reasonably prudent person in his position would not have proceeded with the treatment had the physician adequately disclosed the attendant risks. Again, the issue is not whether the patient himself would have refused treatment given full disclosure; instead, the statute creates yet another objective standard of the reasonably prudent patient.<sup>43</sup>

Second, the plaintiff must prove that the defendant-physician's failure to disclose was the proximate cause of the injury for which damages are sought. The question of proximate causation in a medical malpractice context is defined as a conclusive finding that the injuries complained of would not have

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<sup>42</sup> N.Y. PUB. HEALTH LAW § 2805-d(3) (McKinney 1993).

<sup>43</sup> This objective standard within the statute effectively cut off the trend in the pro-patient, consumer-oriented case law that sought to safeguard the right of individual choice, including the right to make an unreasonable choice. See *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1979) (using subjective standard for causation). "If the patient would have elected to proceed with treatment had he been duly informed of its risks, then the element of causation is missing." *Id.* (emphasis added). The *Bradford* court believed that under a "reasonable man" approach, "a patient's right of self-determination is irrevocably lost." *Id.* at 559; see *MacPherson v. Ellis*, 287 S.E.2d 892, 897 (N.C. 1982) (same). The subjective standard is no longer applied and the patient's credibility is now questioned. The potential difficulty of exposing self-serving falsehood outweighs the patient's right to self-determination. As a result, the objective standard has substituted the subjective standard with the consequence that the new standard may contradict the patient's right to self-determination when his decision deviates from the judgment of the hypothetical "reasonable" or "prudent" person, as though there is one such prudent person response. See *infra* notes 155-72 and accompanying text.

occurred "but for" the doctor's failure to inform the patient of the attendant risks.<sup>44</sup> The plaintiff is not required to establish, for example, that had he elected the treatment option of which he was not advised, the body organ would have been saved.<sup>45</sup> Rather, the issue is whether the negligence of the physician deprived the plaintiff of "a substantial possibility of cure or recovery."<sup>46</sup>

By setting forth an objective test, phrased in terms of the "reasonably prudent person in the patient's position," the legislature has clearly indicated that despite its concern for victims of medical malpractice, it will not permit a patient's hindsight to influence his testimony at trial or to sway the jury.<sup>47</sup> Why, however, foreclose the patient's autonomous choices in the name of the hypothetical "reasonably prudent person?" Rather than granting to the patient a right with one hand and then taking that same right away with the other hand, it appears that imposing a stricter standard of proof to be met by the plaintiff would be more equitable and reasonable.

#### D. Defenses

Section 2805-d(4)<sup>48</sup> of the statute includes four circumstances

<sup>44</sup> New York cases that have accepted the "but for" test of proximate cause include: *Bernard v. Block*, 575 N.Y.S.2d 506 (App. Div. 1991) (concerning myelogram and multiple sclerosis); *Flores v. Flushing Hosp. & Med. Ctr.*, 490 N.Y.S.2d 770 (App. Div. 1985) (involving administration of oxygen to premature baby); *Dries v. Gregor*, 424 N.Y.S.2d 561 (App. Div. 1980) (concerning excision of breast tissue).

<sup>45</sup> See *Crisher v. Spak*, 471 N.Y.S.2d 741, 745 (Sup. Ct. 1983) ("Certainly, the plaintiff is not required to establish that, without question, her leg would have been saved ....").

<sup>46</sup> See *id.* ("The issue, rather, is whether or not the negligence of the defendants deprived [plaintiff] of an appreciable chance of avoiding amputation.").

<sup>47</sup> See *Law's Vision*, *supra* note 3, at 163 (noting that objective test prevents patient's testimony from being influenced by "hindsight and bitterness").

<sup>48</sup> Section 2805-d(4) states:

It shall be a defense to any action for medical, dental or podiatric malpractice based upon an alleged failure to obtain such an informed consent that:

- (a) the risk not disclosed is too commonly known to warrant disclosure; or
- (b) the patient assured the medical, dental or podiatric practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient assured the medical, dental or podiatric practitioner that he did not want to be informed of the matters to which he would be entitled to be informed; or
- (c) consent by or on behalf of the patient was not reasonably possible; or
- (d) the medical, dental or podiatric practitioner, after considering all of

where the medical provider has a defense to a claim that disclosure was necessary. First, a medical provider may raise a defense to an action for medical malpractice if the risk that was not disclosed is "too commonly known to warrant disclosure."<sup>49</sup> Second, an exception to section 2805-d(2) exists if the patient assured the medical provider that he would undergo the treatment "regardless of the risk involved" or that he did not want to be informed of a matter that otherwise would have to be disclosed.<sup>50</sup> Third, if "consent by or on behalf of the patient was not reasonably possible," the medical provider is excused from liability.<sup>51</sup> Finally, the medical provider is not liable if, after appraising all of the "attendant facts and circumstances," he used "reasonable discretion" as to the manner and extent of the disclosure because "he reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition."<sup>52</sup>

Section 2805-d(4) recognizes the notion that the medical provider should be permitted to proceed without first obtaining the patient's consent in those instances where non-disclosure is reasonable. These defenses are rooted in the understanding that the physician-patient relationship is unique.<sup>53</sup> This special relationship allows the doctor to proceed with treatment without first obtaining the consent of his patient.

The last defense, known as the "therapeutic defense," permits the medical provider to argue that since disclosure would have impacted negatively on the patient, information was withheld for the benefit and protection of the patient.<sup>54</sup> Some com-

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the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition.

N.Y. PUB. HEALTH LAW § 2805-d(4) (McKinney 1993).

<sup>49</sup> § 2805-d(4)(a).

<sup>50</sup> § 2805-d(4)(b).

<sup>51</sup> § 2805-d(4)(c).

<sup>52</sup> § 2805-d(4)(d).

<sup>53</sup> See *supra* note 5 (discussing how physician-patient relationship partakes of fiduciary nature).

<sup>54</sup> Section 2805-d(4)(d) provides an affirmative defense to the physician in that he acknowledges the lack of disclosure but can defend against liability if he "reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition." N.Y. PUB. HEALTH LAW § 2805-d(4)(d). The statute appears to have simply codified a defense recognized at common law. See *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.

mentators suggest that the therapeutic defense undermines the essence of the informed consent doctrine since it allows the physician to arrogate the decision-making process to himself instead of encouraging a joint decision-making relationship between the concerned parties.<sup>55</sup> If the goal of the informed consent doctrine is to permit the patient to determine the course of his medical future, why minimize his personal judgment? It appears that the statute is implicitly telling the patient, "we don't trust your judgment."<sup>56</sup>

### III. JUDICIAL INTERPRETATION OF SECTION 2805-d

#### A. *Is an Action for Lack of Informed Consent Grounded in Common Law Assault and Battery or Negligence?*

At common law, a majority of jurisdictions recognized that the nonconsensual touching of a patient by a doctor constituted an assault and battery.<sup>57</sup> In New York, the etiology of that view

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1972) ("The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being.").

<sup>55</sup> See Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413 (1979). Professor Meisel argues that societal and professional interests combine to place responsibility for the promotion of health on the medical profession and not on the individual. *Id.* at 429. This responsibility is misplaced. *Id.* In fact, he argues that the threat posed by this "therapeutic privilege" to self-determination is so great that its abolition should be considered:

Harm is inflicted upon the patient by undermining his right of self-determination when information is withheld as certainly as harm is done by emotionally upsetting him when unpleasant information is conveyed .... But when viewed in light of the great weight accorded individualism and the consequent heavy burden on those who would deny it, the need for a restrictively defined and applied therapeutic privilege is apparent.

*Id.* at 469.

<sup>56</sup> See Meisel, *supra* note 55, at 461. It appears that the legislature, by way of section 2805-d(4)(d), agrees that societal health is best provided by those whose primary duty is to do that which is beneficial for the patient.

<sup>57</sup> See, e.g., *Pratt v. Davis*, 118 Ill. App. 161, 166 (App. Ct. 1905) (holding that surgeon does not have right to violate person of patient by performing serious operation without express or implied consent).

[U]nder a free government at least, the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent ... to violate without permission the bodily integrity of his patient ... and operat[e] on him without his consent or knowledge.

*Id.*; see also *Mohr v. Williams*, 104 N.W. 12, 15-16 (Minn. 1905) (dealing with cause

can be traced to *Schloendorff v. New York Hospital*,<sup>58</sup> in which Judge Cardozo emphatically stated that the mere fact of touching, without an examination of any other factor, was actionable in battery.<sup>59</sup> An implication of this legal predicate is that negligence is not the issue. Thus, under this common law rule, even in those instances where the medical provider's care is superb and cannot be faulted on a theory of negligence—that is, the deviation from the minimum standard of care exercised by the reasonably prudent practitioner in similar circumstances—the theory of battery will be a successful basis for the plaintiff's recovery of damages.<sup>60</sup>

With time, cases arose in which plaintiffs who gave consent to medical procedures later argued that their consent was defective because all risks were not fully disclosed.<sup>61</sup> The next logical argument to be advanced was that this defective consent, based as it was on incomplete information, was the legal equivalent of no consent.<sup>62</sup> This argument was accepted in the case law on a theory of battery.<sup>63</sup>

With the enactment of the Medical Malpractice Act, an issue arose as to how the statute impacted on this battery-negligence dichotomy. In 1980, two cases moved New York law towards a theory of negligence. In *Dries v. Gregor*,<sup>64</sup> an Appellate Division decision, the plaintiff Dries launched a cause of action alleging malpractice arising from a lack of informed consent.<sup>65</sup> Based on

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of action for assault and battery); *Fogal v. Genesee Hosp.*, 344 N.Y.S.2d 552, 559 (App. Div. 1973) (same).

<sup>58</sup> 211 N.Y. 125 (1914).

<sup>59</sup> *Id.* at 130.

<sup>60</sup> See *Fogal*, 344 N.Y.S.2d at 559 ("The cause of action is not based on any theory of negligence but is an offshoot of the law of assault and battery."); see also *Darrah v. Kite*, 301 N.Y.S.2d 286, 290-91 (App. Div. 1969) (finding that injury is that surgeon performed at all, not that surgeon performed incorrectly).

<sup>61</sup> See *Fiorentino v. Wenger*, 272 N.Y.S.2d 557, 559 (App. Div. 1966) (holding that surgeon was obligated to disclose that procedure he proposed was novel and unorthodox), *rev'd on other grounds*, 280 N.Y.S.2d 373 (1967).

<sup>62</sup> See *Darrah*, 301 N.Y.S.2d at 290 ("An uninformed or invalid consent is tantamount to no consent at all.").

<sup>63</sup> See generally *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30 (1914) (holding doctors who perform operations on patients without consent are liable for assault); *Karlsons v. Guerinet*, 394 N.Y.S.2d 933 (App. Div. 1977) (discussing pre-statute common law); *Darrah*, 301 N.Y.S.2d at 290 (extending doctor liability under assault to include situations where patient is unable to make informed consent).

<sup>64</sup> 424 N.Y.S.2d 561 (App. Div. 1980).

<sup>65</sup> *Id.* at 562.



a radiologist's X-ray report that revealed a positive finding of a lesion on plaintiff's right breast, plaintiff agreed to a biopsy of the breast in order to rule out cancer.<sup>66</sup> During the procedure, a partial mastectomy was performed and a substantial amount of breast tissue, which was later found to be benign, was removed.<sup>67</sup> The plaintiff stated in her complaint that "she was neither advised of nor had she consented to" the partial mastectomy procedure.<sup>68</sup> The court reviewed at length the two legal theories of liability arising from a lack of informed consent—battery and negligence.<sup>69</sup> The court discussed the academic writings on the subject that found that the use of assault and battery concepts were declining while use of negligence concepts were on the rise.<sup>70</sup> Indeed, the New York Court of Appeals was persuaded to adopt a negligence standard of review.<sup>71</sup> The court reasoned that assault and battery are intentional torts and, as such, do not logically apply to situations where a doctor unintentionally fails to disclose adequate information.<sup>72</sup> Injuries claimed in lack of consent actions do not arise from an intended harm; rather, they are caused by the doctor's breach of duty to adequately inform. The court therefore concluded that "[f]rom a practical standpoint, the conduct of the parties should be measured by a negligence analysis in both 'informed consent' and 'negligent' malpractice actions."<sup>73</sup> Lower courts continued to echo this theme.<sup>74</sup>

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<sup>66</sup> *Id.* at 563.

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.* at 563 ("The theory of lack of informed consent in medical malpractice actions presents conceptual difficulties arising from the awkward mixture of assault and battery in a suit based upon negligence.").

<sup>70</sup> *Id.* at 564 (citing to Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 416-24 (1957)).

<sup>71</sup> *Id.* (adopting negligence standard because "medical treatment beyond the scope of a patient's consent should not be considered as an intentional tort or species of assault and battery as it had been viewed in the past ....").

<sup>72</sup> Indeed, a doctor is one who "in good faith intends to confer a benefit on the patient." *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> See, e.g., *Rigie v. Goldman*, 543 N.Y.S.2d 983, 986 (Sup. Ct. 1989) (acknowledging modern view that failure of doctor to obtain informed consent is type of malpractice resting in negligence); *Bellier v. Bazan*, 478 N.Y.S.2d 562, 565 (Sup. Ct. 1984) (affirming award against defendants in medical malpractice action where physician was shown to have deviated from proper standards of good medical practice); *Hughson v. St. Francis Hosp.*, 459 N.Y.S.2d 814, 817 (Sup. Ct. 1983) (recognizing mother's right to bring cause of action for negligence against physician who failed to obtain informed consent from mother on behalf of infant).

In *Prooth v. Walsh*,<sup>75</sup> the court examined two theories of liability—assault and battery and negligence—in a medical malpractice action wherein plaintiff claimed that his consent to surgery was vitiated because he was not properly informed of the risks of heart by-pass surgery.<sup>76</sup> During the surgery, a surgical clamp was “inadvertently left in [the patient’s] chest cavity.”<sup>77</sup> During the course of the operation, the surgeons discovered that a clamp was missing, but because of the plaintiff’s erratic heart-beat, they were unable to continue searching the plaintiff’s chest cavity for the clamp.<sup>78</sup> The court, citing to the *Dries*<sup>79</sup> case, noted: “the trend has been toward adoption of a standard applied in other jurisdictions which considers the failure to properly inform the patients of the risks of the operation to be negligence, a lack of due care, within the general principles of professional malpractice.”<sup>80</sup> The battery versus negligence debate has been laid to rest. Today, all causes of action for lack of informed consent in New York are based solely on a theory of negligence.<sup>81</sup>

### B. Who Must Obtain Consent?

The statute requires the “medical, dental or podiatric practitioner” to obtain the patient’s informed consent.<sup>82</sup> At common law, the doctrine of informed consent was applied to doctors and dentists.<sup>83</sup> The 1975 Act extended the coverage of the doctrine to include podiatrists.<sup>84</sup> A significant volume of case law has

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<sup>75</sup> 432 N.Y.S.2d 663 (Sup. Ct. 1980).

<sup>76</sup> *Id.* at 664. The two theories examined by the court were the traditional assault and battery claim for non-consensual contact and the then developing theory of negligence grounded in a breach of duty to inform. *Id.* at 664-65.

<sup>77</sup> *Id.* at 667.

<sup>78</sup> *Id.*

<sup>79</sup> For a discussion of the *Dries* case, see *supra* notes 64-73 and accompanying text.

<sup>80</sup> *Prooth v. Walsh*, 432 N.Y.S.2d 663, 664 (Sup. Ct. 1980) (citing *Dries v. Gregor*, 424 N.Y.S.2d 561 (App. Div. 1980)); see also *Murriello v. Crapotta*, 382 N.Y.S.2d 513, 514 (App. Div. 1976) (finding that claim for lack of informed consent is more consonant with negligence principles than with assault and battery).

<sup>81</sup> See, e.g., *Vargas v. Rosal-Arcillas*, 438 N.Y.S.2d 986 (Sup. Ct. 1981). For an outline of the decline of the battery theory, see *Retkwa v. Orentreich*, 584 N.Y.S.2d 710, 710-12 (Sup. Ct. 1992).

<sup>82</sup> N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 1993).

<sup>83</sup> See *Petterson v. Lynch*, 299 N.Y.S.2d 244, 245 (Sup. Ct. 1969) (holding that informed consent theory of liability shall be imposed upon dentists as well as physicians).

<sup>84</sup> See *Laskowitz v. Ciba Vision Corp.*, 632 N.Y.S.2d 845, 846 (App. Div. 1995) (holding that although legislature codified actions involving medical, podiatric, or

evolved to answer the question of "who is a *medical* practitioner?"

This issue first arose in the New York Supreme Court case *Prooth v. Wallsh*.<sup>85</sup> In *Prooth*, the plaintiff agreed to cardiac surgery after having been referred to a cardiologist and a cardiac surgeon by his treating physician, who was an internist.<sup>86</sup> The court was confronted with the question of which physicians in the medical hierarchy are required to obtain the patient's consent.<sup>87</sup> The court acknowledged that typically the plaintiff's primary physician, in this case his internist, bears the role of gatekeeper for his medical care.<sup>88</sup> Further, the court recognized that the physician cannot himself assume liability for all phases of the patient's treatment, such as the surgery performed by the cardiac specialist.<sup>89</sup> The court therefore acknowledged a limit to liability because the proper duty of a physician is often simply to prescribe "a course of treatment by others, such as specialists."<sup>90</sup>

The question then becomes how the medical referral should be treated and what legal recognition should be granted to this medical axis. The *Prooth* court correlated informed consent to treatment.<sup>91</sup> Therefore, to the extent that treatment is offered, the treating physician must look to his patient for an informed consent.<sup>92</sup> The court further stated:

To the degree that the physician provides such treatment directly, he obviously bears a duty to advise his patients of the risk. Further, if he refers his patient to another physician and retains a degree of participation, by way of control, consultation or otherwise, his responsibility continues to properly advise his

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dental malpractice based on failure to obtain informed consent, it has not rescinded common law doctrine of informed consent).

<sup>85</sup> 432 N.Y.S.2d 663 (Sup. Ct. 1980); see also *supra* notes 75-80 and accompanying text.

<sup>86</sup> *Prooth*, 432 N.Y.S.2d at 664.

<sup>87</sup> *Id.* The plaintiff-patient named as defendants the hospital, his personal treating physician (the internist), the chief surgeon (a private cardiac surgeon) and the assisting surgeon. *Id.*

<sup>88</sup> *Id.* at 665 ("A patient's personal physician bears the responsibility to assure the welfare of his patient in all phases of his treatment.").

<sup>89</sup> *Id.*

<sup>90</sup> *Id.* The court recognized that after the personal physician refers the patient to another doctor, "the second physician also has a duty to inform the patient." *Id.*

<sup>91</sup> The *Prooth* court noted that the doctor's duty is to "explain the particular risks of *his* phase of the treatment, for example, surgery or anesthesia, [and thus] it does not automatically follow that he has an obligation to inform the patient of the risks of another participant's treatment." *Id.* at 665 (emphasis added).

<sup>92</sup> *Id.*

patients with respect to the treatment to be performed by the referred physician.<sup>93</sup>

Hence, the actual treatment engenders the medical provider's dual obligation to disclose the risks and benefits to the patient as well as the duty to obtain the patient's informed consent. Therefore, the specialist to whom the patient has been referred must assume liability for his phase of the treatment.<sup>94</sup> Although treatment defines the medical provider's legal obligation, a collaborative effort between referring and treating physicians is still recognized. The referring physician will continue to have legal responsibilities if he "retains a degree of participation, by way of control, consultation or otherwise."<sup>95</sup> The *Prooth* court chose not to define "control" since its decision that the referring physician is not legally liable for a failure to disclose and to obtain informed consent was sufficient for its ruling.<sup>96</sup>

In 1984, the *Prooth* case and its oblique reference to the referring physician's "participation or control" was revisited. In *Nisenholtz v. Mount Sinai Hospital*,<sup>97</sup> after suffering from ulcerative colitis for ten years, plaintiff-patient agreed to surgery to remove his colon and rectum.<sup>98</sup> Following surgery, the patient became organically impotent as a result of either the surgery or postoperative scarring.<sup>99</sup> The plaintiff-patient claimed that neither his personal physician nor the surgeon discussed the risk of impotence with him.<sup>100</sup> Plaintiff grounded his cause of action on a failure to obtain informed consent claim and sued both the internist, who was the referring physician, and the surgeon who performed the procedure.<sup>101</sup> A question arose as to whether the internist who referred the patient to the specialist could be held

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<sup>93</sup> *Prooth*, 432 N.Y.S.2d at 665.

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* at 666. The court concluded that the treating physician and the chief surgeon are the only parties charged with the duty of obtaining informed consent. *Id.*

<sup>97</sup> 483 N.Y.S.2d 568 (Sup. Ct. 1984).

<sup>98</sup> *Id.* at 569.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.* at 570. One of the defendants, Dr. Glenart, head of the surgical team, advised the plaintiff that impotence was an unlikely but possible risk of the surgery. *Id.* at 569. The plaintiff's expert witness testified that although Dr. Glenart's advice constituted adequate warning of the risk of impotence, the doctor deviated from appropriate standards in obtaining informed consent to the particular operation by not discussing all possible causes of impotence. *Id.* at 569-70.

<sup>101</sup> *Id.* at 569.

liable. The internist neither performed nor recommended the surgery; instead, once the internist determined that the course of non-surgical treatment which he had pursued was no longer an effective course of treatment, he referred the plaintiff to the surgeon.<sup>102</sup> The *Nisenholtz* court examined the *Prooth* decision and found that the simple act of referring a patient to another physician does not create liability for the referring physician and does not impose a duty to obtain informed consent to treatment rendered by the second physician.<sup>103</sup>

The *Nisenholtz* court disagreed with the *Prooth* decision and stated that in order to impose liability, a referring physician must do more than simply retain a "degree of participation."<sup>104</sup> The court found that the internist's action of simply visiting his patient in the hospital during the individual's stay for surgery did not amount to participation.<sup>105</sup> It is unclear from the court's opinion whether the internist billed for these hospital visits. The court did not discuss whether the billing for the internist's visits would have entailed different legal consequences. However, the court did recognize a factor that would engender liability: "[t]he referring physician should be held liable only when that physician has ordered a procedure or actually participates in the treatment or procedure."<sup>106</sup>

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<sup>102</sup> *Id.* at 572-73. The internist did, however, advise the plaintiff to seriously consider the surgery. *Id.* at 573.

<sup>103</sup> *Id.* at 573 ("[T]he mere act of referring a patient to another physician is insufficient to create liability on the part of the referring physician to obtain informed consent to treatment rendered by the second physician ...."). Other jurisdictions also have not conferred liability to referring physicians or assistants who neither ordered nor performed the procedure. *See, e.g.,* *Harnish v. Children's Hosp. Med. Ctr.*, 439 N.E.2d 240, 245 (Mass. 1982) (stating that no case law exists that would impose duty of informed consent on surgical assistant); *Prooth v. Wallsh*, 432 N.Y.S.2d 663, 666 (Sup. Ct. 1980) (indicating that treating physician and chief surgeon had duty to obtain consent); *Rittes v. Delany*, 790 S.W.2d 29, 30-32 (Tx. Ct. App. 1990) (holding that only operating physician had duty to obtain informed consent).

<sup>104</sup> *Nisenholtz*, 483 N.Y.S.2d at 573 ("For liability to arise, the referring physician must do more than retain 'a degree of participation,' as described in *Prooth*."); *see also infra* note 106 and accompanying text.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.* In *Graddy v. New York Medical College*, 243 N.Y.S.2d 940 (App. Div. 1963), the court stated that liability imposed on one physician for the actions of another is "limited to situations of joint action in diagnosis or treatment or some control of the course of treatment of one by the other." *Id.* at 943. The *Prooth* court interpreted this to apply to a referring physician who "retains a degree of participation, by way of control, consultation or otherwise ...." *Prooth*, 432 N.Y.S.2d at 665. The *Nisenholtz* court disagreed with such an expansive interpretation. *Nis-*

The *Nisenholtz* holding was later refined by the Appellate Division in *Spinosa v. Weinstein*.<sup>107</sup> The defendant, Dr. Weinstein, was a podiatrist who performed a series of thirty-four surgical procedures to remove bunions and to correct the misalignment of the plaintiff's toes.<sup>108</sup> The plaintiff asserted that as a consequence of this surgery, her toes became hammered and her feet caused her constant pain.<sup>109</sup> Also named as defendant was Dr. Hochran, who was the surgical assistant during these procedures, during which he administered local anesthetics and handed instruments to Dr. Weinstein—the treating podiatrist.<sup>110</sup> Dr. Hochran performed no actual surgery on plaintiff's feet; instead, his interaction with the plaintiff was limited to post surgical follow-up care.<sup>111</sup>

One of the central issues in *Spinosa* was whether liability should be imposed on Dr. Hochran for a failure to obtain informed consent. Under the *Nisenholtz* standard, responsibility is not to be imposed on a medical provider who neither performed nor ordered the procedure.<sup>112</sup> In *Spinosa*, the plaintiff argued that the *Nisenholtz* facts should be distinguished based on the degree of Dr. Hochran's participation in the plaintiff's care.<sup>113</sup> Accordingly, the plaintiff sought to hold the surgical assistant, Dr. Hochran, liable for failure to obtain informed consent on the basis that he could be considered a "person providing the professional treatment"<sup>114</sup> within the meaning of section 2805-d(1).

While the court recognized that Dr. Hochran's participation in the patient's care exceeded that of the referring physician in *Nisenholtz* and that he could therefore be considered a "person providing the professional treatment,"<sup>115</sup> the court refused to ex-

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*enholtz*, 483 N.Y.S.2d at 573.

<sup>107</sup> 571 N.Y.S.2d 747 (App. Div. 1991).

<sup>108</sup> *Id.* at 749.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 749-50.

<sup>111</sup> *Id.* at 750. Part of Dr. Hochran's follow-up care included removing sutures and changing bandages. *Id.*

<sup>112</sup> *Nisenholtz*, 483 N.Y.S.2d at 573; see *supra* notes 97-106 and accompanying text.

<sup>113</sup> *Spinosa*, 571 N.Y.S.2d at 752.

<sup>114</sup> *Id.*

<sup>115</sup> *Id.* ("[W]e recognize that Dr. Hochran can be considered a 'person providing the professional treatment' within the meaning of Public Health Law § 2805-d(1) ...."). The *Spinosa* court also distinguished the degree of participation by the assisting physician in the instant case from that of the assistant in *Prooth*. *Id.* In *Prooth*, since the assisting surgeon was "called in to [sic] the operation by the chief surgeon

tend liability in such a case because it would require the physician to inform the patient of the risks involved in the treatment rendered by others.<sup>116</sup> Interpreting section 2805-d(1) broadly so as to impose liability in such cases would ultimately backfire and harm the patient because, by being constantly advised of the same risks, the patient would be discouraged from agreeing to necessary treatment.<sup>117</sup>

In *Hill v. Seward*,<sup>118</sup> the New York Supreme Court further analyzed the issue of which actors in the medical hierarchy should be held liable for not procuring an informed consent. The *Hill* court held that although a medical resident is an important member in a teaching hospital, a resident cannot be held accountable for failing to obtain the patient's informed consent even if he in fact discussed the surgery with the patient.<sup>119</sup> Performance or participation in the treatment or procedure triggers the legal requirement to obtain a patient's informed consent. The court reasoned that in spite of the numerous occasions in which the resident interacted with the patient, the resident cannot be held liable because he did not perform or participate in the surgery in any manner.<sup>120</sup> Thus, even in cases where the information is provided by a person with the qualifications to inform, liability nevertheless may only be imposed on the treating physician.<sup>121</sup>

In a later case, the Appellate Division, in *Brandon v. Karp*,<sup>122</sup>

and [was] answerable [only] to him," the assisting physician was not liable for the results of the procedure performed by the chief surgeon. 432 N.Y.S.2d 663, 665-66 (Sup. Ct. 1980).

<sup>116</sup> *Spinosa*, 571 N.Y.S.2d at 752.

<sup>117</sup> *Id.* But see Richard E. Simpson, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U. L. REV. 172, 195 (1981) (asserting that greater number of disclosure sessions increase patient's ability to understand relevant information).

<sup>118</sup> 470 N.Y.S.2d 971 (Sup. Ct. 1983).

<sup>119</sup> *Id.* at 972 (finding that doctor who discusses surgery with patient is not liable for lack of informed consent unless he actually performs or participates in surgery).

<sup>120</sup> *Id.* at 972 ("The law ... does not impose on the doctor who discusses the surgery with the patient any liability for surgery performed without informed consent unless that doctor performs or participates in the performance of the surgery."); see also *Prooth*, 432 N.Y.S.2d at 665 (stating that duty to obtain informed consent rests with physician who is treating patient).

<sup>121</sup> *Hill*, 470 N.Y.S.2d at 972 (stating that failure of resident doctor to disclose risks of procedure may impose liability on treating physician, but not on resident physician).

<sup>122</sup> 490 N.Y.S.2d 904 (App. Div. 1985).

reaffirmed the requirement that the treating physician secure an informed consent from his patient.<sup>123</sup> In *Brandon*, a nurse misinformed the patient of a treatment procedure while acquiring the plaintiff's signature on a consent form.<sup>124</sup> The misinformation, however, was corrected by the treating physician immediately prior to the initiation of treatment.<sup>125</sup> Although an erroneous impression may have been created in the plaintiff's mind, the court held that since this impression was corrected within a timely manner, such misinformation cannot establish the basis of a lawsuit based on the failure to obtain informed consent.<sup>126</sup> The court's rationale in cases such as *Brandon* is questionable where, at the time of the actual procedure, the patient is less focused and arguably unable to give an informed consent.<sup>127</sup> In es-

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<sup>123</sup> *Id.* at 906. The court emphasized that Public Health Law § 2805-d(1) places responsibility to disclose only on the professional who provides treatment or diagnosis. *Id.*

<sup>124</sup> *Id.* at 905.

<sup>125</sup> *Id.*

<sup>126</sup> *Id.* at 906 ("Since [the treating physician] corrected the misinformation before performing the procedure, and plaintiff did not object after learning of the actual nature of the procedure, the nurse's error could not have been a proximate cause of any alleged injury ....").

<sup>127</sup> Although the nurse and the physician in *Brandon* discussed the procedure with the plaintiff on the same day, the length of time that passed between each consultation is not part of the record. *Id.* at 905. There is at least some risk that a patient may not provide informed consent when presented with information immediately prior to the procedure. See Simpson, *supra* note 117, at 195 (noting that patient is more likely to fully comprehend information given prior to granting consent if he has sufficient time to weigh all factors). Although New York's Public Health Law requires disclosure of information "in a manner permitting the patient to make a knowledgeable evaluation," N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 1993), the law does not mandate any procedure to ensure the patient's understanding of the information. While this may be implicitly stated in the statute, the court in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), stated that "the focus of attention is more properly upon the nature and content of the physician's divulgence than the patient's understanding or consent." *Id.* at 780 n.15. New York adopted the *Canterbury* rationale in *Fogal v. Genessee Hospital*, 344 N.Y.S.2d 552 (App. Div. 1973), focusing on the standard to apply when determining whether disclosure is adequate. *Id.* at 559. The *Fogal* court held that a doctor is obliged to divulge all risks that a patient should reasonably know and that may affect the patient's decision regarding treatment. *Id.* The court, however, did not require a demonstration of the patient's understanding in order to show adequate disclosure. *Id.*; see generally Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 406-27 (1990) (discussing various reasons why patients typically do not fully understand information given to them by physicians, and recommending ways to avoid this lack of comprehension). For other articles suggesting improvements to the informed consent process, see Miller & Willner, *The Two-Part Consent Form: A Sug-*



sence, the court sent a message to patients that they must examine the source of their information. Since a nurse has no authority to obtain consent, the information necessary to form consent can only be conveyed by the treating physician.<sup>128</sup> Hence, after consideration of the cases discussed in this section, it appears that the legal theme is that only those medical providers who prescribe treatment or perform the medical procedure are obligated to obtain the patient's informed consent.

A recent decision of the New York Court of Appeals in this area is *Rosenberg v. Equitable Life Assurance Society of the United States*,<sup>129</sup> which commented on the legal requirements for obtaining informed consent when an insurance company is the referring party. In *Rosenberg*, the plaintiff brought a wrongful death action upon the death of her husband, who died of cardiac failure resulting from the administration of a stress electrocardiogram (EKG) ordered by the insurance company as a precondition to obtaining life insurance.<sup>130</sup> The decedent had a history of heart disease and had suffered a heart attack eight years prior to his death.<sup>131</sup> The insurer's form required that a Dr. Arora perform an EKG to complete decedent's insurance application.<sup>132</sup> The insurance company thereby referred the decedent to Dr. Arora, a physician of its choice, for evaluation.<sup>133</sup> Plaintiff's expert testified at trial that the EKG was potentially dangerous under the circumstances. Upon these facts, the jury found that the EKG was the proximate cause of decedent's death.<sup>134</sup> On appeal, the New York Court of Appeals considered two main issues: first, whether the insurance company was vicariously liable for the negligence of Dr. Arora; and second, whether the company was liable for its own negligence in ordering the EKG and failing to obtain decedent's informed consent to the examination.<sup>135</sup>

The Court of Appeals found that the physician in this case

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*gestion for Promoting Free and Informed Consent*, 290 NEW ENG. J. MED. 964 (1974); and Simpson, *supra* note 117, at 192-95.

<sup>128</sup> *Brandon*, 490 N.Y.S.2d at 906; see also *Cirella v. Central Gen. Hosp.*, 630 N.Y.S.2d 93, 94 (App. Div. 1985) (refusing to hold hospital liable, notwithstanding fact that hospital employee undertook ministerial task of recording consent).

<sup>129</sup> 595 N.E.2d 840 (N.Y. 1992).

<sup>130</sup> *Id.* at 842.

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.* at 842-43.

<sup>135</sup> *Id.*

was an independent contractor, and as such the insurance company was not vicariously liable for his negligence.<sup>136</sup> More importantly, in addressing the second issue, the court noted that the doctor was bound by the Hippocratic Oath to do no harm and by a legal duty under section 2805-d to perform dangerous procedures only with the patient's informed consent.<sup>137</sup> According to the court, the doctor should never be required to subordinate this professional judgment upon request by another party, even if the request is made by the insurance company that pays the doctor's fees.<sup>138</sup> While the insurer may tug at the purse strings, it should not be able to control how the physician practices his profession. Once the physician uses his/her professional judgment to administer a given medical procedure, the duty to explain the risks of that examination to the patient and to obtain the patient's consent belongs to the physician alone.<sup>139</sup> In *Rosenberg*, the insurance company could not have reasonably anticipated that the physician would disregard these responsibilities and administer the EKG when doing so would be dangerous to the patient.<sup>140</sup> Moreover, according to the court, the company could have reasonably expected that the possible risks of a stress EKG would be disclosed to the decedent.<sup>141</sup> Since the insurance company had neither a duty to explain the risks of the medical exam to the patient nor a duty to obtain his informed consent before referring him to a physician, the court found that the insurance company could not be held liable.<sup>142</sup>

## B. *What Must Be Disclosed?*

### (i) Scope of Disclosure

After the passage of section 2805-d, courts adhered to a two-fold test to determine the scope of information that must be dis-

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<sup>136</sup> *Id.*

<sup>137</sup> *Id.* at 844.

<sup>138</sup> *Id.* at 845 ("[N]o medical doctor can be *required* to render services which, in the doctor's professional judgment, are dangerous or contraindicated and public policy is not served by imposing liability for the doctor's fault in doing so on the insurer.").

<sup>139</sup> *Id.* at 844-45 (finding doctor, not insurer, had duty to disclose risks of procedure).

<sup>140</sup> *Id.* at 844.

<sup>141</sup> *Id.*

<sup>142</sup> *Id.* at 845.

closed to the patient. First, measured from the medical provider's point of view, the statute requires the physician to disclose reasonably foreseeable risks that a "reasonable ... practitioner under similar circumstances" would have disclosed to the patient.<sup>143</sup> Consequently, to pursue a cause of action, the plaintiff-patient must establish that the medical provider's discussion with the patient does not comport with what a practitioner under similar circumstances would have disclosed.<sup>144</sup> Second, the information disclosed must, from the vantage point of the patient, be sufficient to allow a "reasonably prudent person in the plaintiff's position" to make a knowledgeable evaluation.<sup>145</sup> Section 2805-d essentially codified the common law, which implies the reasonably prudent patient and reasonable practitioner tests in an action for medical malpractice based on lack of informed consent.<sup>146</sup>

In determining whether the scope of information disclosed by the medical provider is legally sufficient, the reviewing court must first determine what a reasonable practitioner in similar circumstances would have disclosed. Under the statute, the physician has the duty to disclose alternatives to the treatment or diagnosis and the reasonably foreseeable risks and benefits

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<sup>143</sup> N.Y. PUB. HEALTH LAW § 2805-d(1).

<sup>144</sup> See, e.g., *Shkolnik v. Hospital for Joint Diseases Orthopedic Inst.*, 627 N.Y.S.2d 353, 355 (App. Div. 1995) (noting that plaintiff has burden of establishing physician's failure to disclose that which reasonably prudent doctor would have disclosed); *Bernard v. Block*, 575 N.Y.S.2d 506, 511 (App. Div. 1991) (noting that plaintiff-patient bears burden of proof).

<sup>145</sup> N.Y. PUB. HEALTH LAW § 2805-d(3).

<sup>146</sup> See *Lipsius v. White*, 458 N.Y.S.2d 928, 934 n.4 (App. Div. 1983) (stating that section 2805-d codifies New York majority rule regarding informed consent); *Dries v. Gregor*, 424 N.Y.S.2d 561, 565 n.2 (App. Div. 1980) (noting that section 2805-d codifies court's analysis that plaintiff must prove that reasonably prudent person in plaintiff's position would not have consented to procedure); *Pagan v. State*, 476 N.Y.S.2d 468, 468-69 (Ct. Cl. 1984) (stating that statute codifies unique elements of informed consent which must be proven at trial). But see *Jeffrey A. Schreiber, A Case Study of Informed Consent Doctrine in New York*, 53 N.Y. ST. B.J. 431, 433-34 (1981) (characterizing assertion in *Dries* decision that section 2805-d codifies common law as "misstatement" because section 2805-d imposes "stringent cause-in-fact" element); cf. *Laskowitz v. Ciba Vision Corp.*, 632 N.Y.S.2d 845, 849 (App. Div. 1995) (holding that whereas section 2805-d includes only doctors, dentists and podiatrists, "optometrists and other health care professionals" are still bound by common law duty to obtain patient's informed consent); *Bellier v. Bazan*, 478 N.Y.S.2d 562, 563 (Sup. Ct. 1984) (holding that although section 2805-d(4) does not include plaintiff's culpable conduct as defense in informed consent actions, common law mitigation of damages for such conduct still applies).

that a reasonable physician would disclose under similar circumstances in order to permit the patient to make an informed choice as to his medical treatment.<sup>147</sup>

Courts must determine, on a case by case basis, what information is significant and material in the particular case and what level of disclosure is necessary to satisfy the first prong of the test. For instance, in *Ogden v. Bhatti*,<sup>148</sup> the court determined that all risks need not be disclosed. In *Ogden*, the plaintiff had a colonoscopy and a polypectomy performed to remove a polyp in the sigmoid colon.<sup>149</sup> During the procedure, a perforation was discovered at the polypectomy site, requiring immediate surgery.<sup>150</sup> Following the surgery, plaintiff instituted an action based on malpractice and a failure to obtain informed consent.<sup>151</sup> The plaintiff alleged that the specific risk of perforation was not mentioned to her, and therefore her consent to the polypectomy was not informed.<sup>152</sup> The defendant-physician countered by stating that only general risks had to be mentioned under the circumstances, implying that the physician need not disclose the particular risks of perforation unless asked specifically by the patient.<sup>153</sup> In affirming the trial court, the appellate court determined that, based upon the record, a rational juror could reasonably conclude that the pertinent disclosure conformed with what a reasonable physician under similar circumstances would have divulged.<sup>154</sup> Hence, this obviated the need to disclose all risks to the patient. As a result, some initiative is left to the patient so that he/she may question the physician as to specific risks, research the medical issues and seek their resolution.

After the reviewing court determines that the plaintiff-patient has proven the first prong of the test, it must then examine whether the second prong—the reasonably prudent patient test—has been satisfied. In 1980, the Appellate Division in *Dries*

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<sup>147</sup> See N.Y. PUB. HEALTH LAW § 2805-d(1); see also *Abrams v. Children's Hosp.*, 542 N.Y.S.2d 418, 418 (App. Div. 1989) (defining informed consent as providing professional treatment to disclose to patient reasonably foreseeable risks and benefits).

<sup>148</sup> 460 N.Y.S.2d 166 (App. Div. 1983).

<sup>149</sup> *Id.* at 167.

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> *Id.* at 168.

<sup>154</sup> *Id.* at 167.

*v. Gregor*<sup>155</sup> followed the reasonably prudent person in the patient's position analysis established at common law in a cause of action based on negligence for failure to obtain the patient's informed consent.<sup>156</sup> The Appellate Division adopted the objective test and found that the hypothetical reasonably prudent person would not have consented to the procedure performed in the instant case.<sup>157</sup> In *Dries*, the plaintiff was referred by her gynecologist to defendant-surgeon Dr. Gregor after a radiologist's report revealed a lesion in her right breast.<sup>158</sup> Prior to any surgery, Dr. Gregor advised the plaintiff to undergo a biopsy procedure, which he described to plaintiff as a procedure that was to be performed under anesthesia and in which only a small sample of breast tissue would be removed for analysis.<sup>159</sup> Instead, the doctor performed a "quadrant resection," which removed approximately three segments totaling two and one-half to two and three-quarter inches of the patient's right breast.<sup>160</sup> After the procedure, the plaintiff discovered that the "top of [her right] breast was gone."<sup>161</sup> Eventually, it was determined that the tissue was not cancerous.<sup>162</sup> The court found that the discrepancy between what the patient was told and what actually transpired was substantial enough to warrant the conclusion that a reasonably prudent person would not have consented to the procedure actually performed.<sup>163</sup>

One cannot help but wonder whether the plaintiff would have been as successful in the *Dries* case had the biopsy procedure identified a cancerous condition. If the court allowed the

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<sup>155</sup> 424 N.Y.S.2d 561 (App. Div. 1980).

<sup>156</sup> *Id.* at 563-65. Apparently, the *Dries* court did not base its analysis on section 2805-d because the surgery was conducted in 1974, prior to the Act's passage. See *id.* at 565 n.2.

<sup>157</sup> *Id.* at 565.

<sup>158</sup> *Id.* at 563.

<sup>159</sup> *Id.* (noting that plaintiff testified that Dr. Gregor told her "a snip" was to be removed from her breast).

<sup>160</sup> *Id.* at 562-63. The plaintiff testified that she was never advised that Dr. Gregor would perform a quadratic resection or "partial mastectomy." *Id.* at 563. Dr. Gregor did not dispute plaintiff's description of the scope of his disclosure. *Id.*

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *Id.* at 565. The trial court charged the jury that, in order to find that there had been a lack of informed consent, they would have to determine first whether a reasonably prudent person would have consented to the surgery performed on the patient. *Id.* The jury found a lack of informed consent, and the Appellate Division did not dispute this finding. *Id.*

outcome of the procedure to influence its decision, it has transgressed the basic purpose of the objective test—that is, the avoidance of the bias caused by hindsight and its twenty/twenty perception.<sup>164</sup> For this reason, the outcome of the treatment or procedure should not be a factor in applying the objective test.

An issue remains as to how courts are to translate the double-pronged test into language that the jury, which is comprised of laypersons, can understand. In *Troy v. Long Island Jewish Hillside Medical Center*,<sup>165</sup> the Appellate Division ruled on this issue but failed to set forth a clear rule or test to guide other courts. In *Troy*, the trial judge interpreted the “reasonable medical practitioner under similar circumstances” test to require a “doctor ... [to] give the patient all the options he has available to him and then allow the patient to make his choice.”<sup>166</sup> The Appellate Division found that the trial judge erred in his instructions to the jury.<sup>167</sup> By characterizing the trial judge’s charge as error, the court implied that a trial judge must state the test specifically in terms of the “reasonable medical practitioner under similar circumstances” formulation so that the jury understands that the acts of the medical provider are being compared to and measured by those of the reasonably prudent practitioner.<sup>168</sup> Trial judges are in a predicament: first, they must en-

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<sup>164</sup> See *Canterbury v. Spence*, 464 F.2d 772, 790-91 (D.C. Cir. 1972) (“[The subjective] method ... comes in second-best. It places the physician in jeopardy of the patient’s hindsight and bitterness.”); *Barnette v. Potenza*, 359 N.Y.S.2d 432, 437 (Sup. Ct. 1974) (stating that justice would not be served by irrational process of jury reliance on patient’s hindsight); see also Hal R. Arkes & Cindy A. Schipani, *Medical Malpractice v. the Business Judgment Rule: Differences in Hindsight Bias*, 73 OR. L. REV. 587, 590 (1994) (stating that “there is no reason why hindsight bias ought to be tolerated in cases of medical malpractice”); Mary Ann Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U. PITT. L. REV. 291, 347 n.202 (1994) (noting risks of subjective standard because “patients might always claim that they *would have* rejected the proposed treatment had they known of the undisclosed risk”) (emphasis added); cf. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 918-19 (1994) (positing that potential bias of plaintiff’s subjective testimony regarding whether she would have consented may be reason most states, although permitting such testimony, opt for objective standard). But cf. Dieter Giesen, *Vindicating the Patient’s Rights: A Comparative Perspective*, 9 J. CONTEMP. HEALTH L. & POL’Y 273, 299 (labeling objective test as insufficient means of indicating patient’s need to determine what is to be done to her body and finding subjective test more suitable).

<sup>165</sup> 446 N.Y.S.2d 347 (App. Div. 1982).

<sup>166</sup> *Id.* at 349.

<sup>167</sup> *Id.* at 349-50.

<sup>168</sup> *Id.* at 349 (holding that trial judge’s misstatement of legal standard may have

sure that juries understand the legal standards upon which they will decide the case; and second, they must not alter the test to the point where it becomes a misstatement of the standard.<sup>169</sup>

As a consequence of this objective test, some courts, in their application of the test, have denigrated the need for the patient's informed consent in certain situations where "the jury could reasonably [find] that an informed, reasonably prudent person would nevertheless have consented to the treatment."<sup>170</sup> This rationale seems to undermine the very essence of the principle of patient self-determination.<sup>171</sup> If the goal of the principle of autonomy is to grant the patient the right to guide his treatment, including the right to refuse treatment already initiated,<sup>172</sup> then the court's granting to the jury the ability to fall back on the concept of the "reasonably prudent person," who may consent to treatment despite the lack of appropriate information for the particular patient-plaintiff, effectively destroys the notion of choice.

In *Kuncio v. Millard Fillmore Hospital*,<sup>173</sup> the failure to obtain informed consent arose at a point in time when the state of medicine was not of the same caliber as at the date of trial.<sup>174</sup>

caused jury to misunderstand appropriate standard).

<sup>169</sup> See *Dries v. Gregor*, 424 N.Y.S.2d 561, 565 (App. Div. 1980) (reversing trial court because question posed during jury charge confused jury concerning element of causation which had previously established liability based on lack of informed consent). For other informed consent cases involving discussion of erroneous jury charges, see *Radloff v. Adler*, 613 N.Y.S.2d 779, 780 (App. Div. 1994) (holding that judge's error of giving jury obsolete instruction on informed consent charge was harmless); *Kasenetz v. Vieta*, 568 N.Y.S.2d 383, 383 (App. Div. 1991) (holding trial court did not err in charge regarding section 2805-d defenses); and *Ogden v. Bhatti*, 460 N.Y.S.2d 166, 168 (App. Div. 1983) (upholding trial court's charge).

<sup>170</sup> *Kuncio v. Millard Fillmore Hosp.*, 499 N.Y.S.2d 525, 527 (App. Div. 1986); see *Becker v. Schwartz*, 46 N.Y.2d 401, 412 (1978) (refusing to legally recognize claim of negligence "dependent upon a comparison between Hobson's choice of life in an impaired state and nonexistence" based on defendant's failure to inform patients of their choices); *Joswick v. Lenox Hill Hosp.*, 570 N.Y.S.2d 803 (Sup. Ct. 1986) (stating that it was unreasonable to conclude that parents of infant would have refused life saving procedures even if they had been informed of possible risk of brain damage).

<sup>171</sup> See *supra* notes 7-10 and accompanying text.

<sup>172</sup> See *supra* notes 11-13 and accompanying text.

<sup>173</sup> 499 N.Y.S.2d 525 (App. Div. 1986).

<sup>174</sup> *Id.* at 526 (stating that issue was "whether the administration of supplemental oxygen was a deviation from accepted standards of practice in March 1953" because there was no dispute that "since 1954 medical science ... [had] uniformly recognized exposure to increased oxygen levels as the leading cause of RLF [retrolental fibroplasia]").

Such differences related both to the protocols of treatment as well as to the practical aspects of medical office practice. In the *Kuncio* case, the treatment procedure for premature babies at birth was significantly different from its practice at trial.<sup>175</sup> In fact, the defendant-physicians conceded that they did not obtain the patient's consent, but they argued that such consent was not necessary given the state of medicine at the time.<sup>176</sup> In their argument, the defendants alluded to the community standard of practice without using the statutory "reasonably prudent practitioner in similar circumstances" standard.<sup>177</sup> The Appellate Division agreed with this argument and imported into its opinion a meaning that even the defendants could not have intended. The defendants simply argued that they could not be held accountable for a standard of medical practice to which they conformed as it was the duty of the parents to obtain the consent.<sup>178</sup> The court furthered this argument by concluding that "the jury could reasonably have found that ... [a] reasonably prudent person would nevertheless have consented to the treatment."<sup>179</sup> Consequently, the failure to inform the patient, in this instance, is irrelevant.

The *Kuncio* case can be restricted to its particular facts. In *Kuncio*, there existed a question of emerging trends in both the areas of medical treatment as well as medical administrative procedure. Is the medical provider to be sanctioned for failure to obtain consent when a particular treatment had not yet fully emerged as the definitive community practice? At least in *Kuncio*, the court refused to append legal liability in the case where the medical provider failed to inform the patient of the risks concerning a particular treatment that had not yet fully emerged as the definitive community practice.

Similarly, the New York Court of Appeals, in *Becker v. Schwartz*,<sup>180</sup> restricted the ability of a plaintiff to make an argument of negligence based on defendant's failure to obtain informed consent.<sup>181</sup> There, plaintiff, who was thirty-seven years of

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<sup>175</sup> *Id.* at 526-27.

<sup>176</sup> *Id.* at 527.

<sup>177</sup> *Id.*

<sup>178</sup> *Id.* at 527 ("[D]efendant argued ... that informed consent was unnecessary at that time given the state of the art.").

<sup>179</sup> *Id.*

<sup>180</sup> 413 N.Y.S.2d 895 (1978).

<sup>181</sup> *Id.* at 898.



age, conceived a child born brain damaged and suffering from Down's Syndrome.<sup>182</sup> Plaintiff argued that the defendant-physician's failure to warn her of the increased risk of Down's Syndrome in children born to women over thirty-five years of age and to inform her of the availability of the amniocentesis test to detect chromosomal abnormality associated with Down's Syndrome constituted medical malpractice.<sup>183</sup> In essence, plaintiff was not informed of her choices.<sup>184</sup> The results of an amniocentesis test would likely have precipitated plaintiff's decision to terminate the pregnancy.<sup>185</sup> As a result, plaintiff sought damages on behalf of the infant for wrongful life.<sup>186</sup> The Court of Appeals refused to extend the principle of autonomy to the extent pushed by the plaintiff.<sup>187</sup> The court characterized the plaintiff's claim as a "demand[] [for] a calculation of damages dependent upon a comparison between Hobson's choice of life in an impaired state and nonexistence ... [a] comparison the law is not equipped to make."<sup>188</sup> As a necessary corollary, the defendant's failure to inform the patient was without effect where the court determined that the infant did not suffer any legally cognizable injury.<sup>189</sup>

Similarly, in *Joswick v. Lenox Hill Hospital*,<sup>190</sup> the parents of a young child were confronted with the proverbial choice between the devil and the deep blue sea. A child was born with a congenital abnormality involving transposition of the aorta with the pulmonary artery, causing blood to circulate without first being oxygenated.<sup>191</sup> A dangerous operation known as a "mustard procedure" was necessary to correct this abnormality. The parents were informed that the surgery was vital for the child's survival, and that even then, the baby had only a ten percent chance of living.<sup>192</sup> The child's mother testified that she

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<sup>182</sup> *Id.* at 896.

<sup>183</sup> *Id.* at 897.

<sup>184</sup> *Id.* at 899 (noting that plaintiffs argued that "had [they] been properly advised by defendants of the risks of abnormality, their infant[] would never have been born").

<sup>185</sup> *Id.* at 898.

<sup>186</sup> *Id.* at 897.

<sup>187</sup> *Id.* at 901.

<sup>188</sup> *Id.* at 900.

<sup>189</sup> *Id.* at 901.

<sup>190</sup> 510 N.Y.S.2d 803 (Sup. Ct. 1986).

<sup>191</sup> *Id.* at 804.

<sup>192</sup> *Id.* at 805.

"was willing to submit her daughter to surgery for 'whatever possible chance the surgery would offer' her child."<sup>193</sup> Although the operation was successful, the child became severely retarded following the procedure.<sup>194</sup> The defendant-physicians were sued on grounds that they had not informed the parents of the risk of possible brain damage.<sup>195</sup> The parents argued that they would not have consented to the mustard procedure if warned of the risk of brain damage, even though failure to operate would have resulted in certain death.<sup>196</sup>

The *Joswick* court began its analysis with the assumption that a parent may not deprive a child of life-saving treatment where the deprivation will result in death.<sup>197</sup> The court found that, in light of the second part of the test under the statute—specifically that plaintiff must show that a reasonable person in a similar position would not have consented to the procedure—it was unreasonable to conclude that parents in plaintiffs' position would have refused the procedure even if they had been informed of possible brain damage.<sup>198</sup> It appears the court was positing that there is no autonomous self-determination granted to the patient where they must choose between mental retardation and certain death. Hence, it is submitted that an analysis of the cases discussed in this subsection lead to the conclusion that certain issues are simply not on the table for discussion, no matter how material they may be to the plaintiff's evaluation.

#### (ii) Disclosure and Training Qualifications

The Appellate Division, in *Abram v. Children's Hospital of Buffalo*,<sup>199</sup> has declared that the medical provider also need not inform patients of the qualifications of personnel providing treatment.<sup>200</sup> The plaintiff-patient in *Abram* moved to amend his medical malpractice complaint to add a cause of action based on lack of informed consent claiming that he was never fully informed of the level of participation of certain under-qualified at-

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<sup>193</sup> *Id.*

<sup>194</sup> *Id.*

<sup>195</sup> *Id.* at 805.

<sup>196</sup> *Id.*

<sup>197</sup> *Id.* ("Moreover, a parent may not deprive a child of life-saving treatment, where the only alternative is certain death.").

<sup>198</sup> *Id.*

<sup>199</sup> 542 N.Y.S.2d 418 (App. Div. 1989).

<sup>200</sup> *Id.* at 419.

tendants.<sup>201</sup> The *Abram* court found that the statute restricted the disclosure requirement to discussion of diagnosis, alternatives and reasonably foreseeable risks to treatment.<sup>202</sup> The court stated that the legislation was specifically restricted to those areas and as such could not be "reasonably read ... to require disclosure of qualifications of personnel providing treatment."<sup>203</sup>

### (iii) Disclosure and Administrative Agencies

A novel question regarding the scope of risk assessment was presented in *Retkwa v. Orentreich*.<sup>204</sup> There, plaintiff brought a cause of action alleging lack of informed consent based on physician's failure to reveal information regarding the Food and Drug Administration (FDA) status of liquid injectable silicone.<sup>205</sup> Essentially, the physician did not reveal that the silicone had not yet been approved by the FDA. Plaintiff argued that this information constituted a risk within the meaning of the statute.<sup>206</sup> The question arose as to whether such information concerning the action of a government agency is the type of information of which a patient must be made aware so as to facilitate his evaluation and decision-making process. The *Retkwa* court held that the information was of such a nature that a reasonable patient would want its divulgence and thereby denied the physician's motion to exclude evidence and testimony that injectable silicone was still unapproved by the FDA.<sup>207</sup>

The court traced the history of New York's informed consent doctrine from the objective physician-based standard to the patient-based materiality standard enunciated in *Canterbury v. Spence*<sup>208</sup> back to the objective professional standard with the en-

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<sup>201</sup> *Id.* at 418.

<sup>202</sup> *Id.*

<sup>203</sup> *Id.* at 419.

<sup>204</sup> 584 N.Y.S.2d 710 (Sup. Ct. 1992).

<sup>205</sup> *Id.* at 710.

<sup>206</sup> *Id.* Defendant made a motion, *in limine*, to exclude evidence and testimony that liquid injectable silicone was not approved by the FDA. *Id.*

<sup>207</sup> *Id.* at 712 ("There can be little question that in assessing the risk of a drug or injectable substance, a reasonable patient would want information as to whether that drug or substance has been tested and/or approved by Federal authorities.").

<sup>208</sup> In *Canterbury v. Spence*, the court held that the duty to disclose and the scope of disclosure are determined by a general standard of conduct reasonable under all circumstances. 464 F.2d 772, 785 (D.C. Cir. 1972). According to the *Canterbury* court, the test for determining when a risk must be disclosed is whether such risk will materially affect the patient's decision to proceed with the procedure. *Id.* at 787. The *Canterbury* court noted that the duty to disclose should not be measured

actment of the 1975 statute.<sup>209</sup> The court then examined case law from Arizona that applied the objective professional standard.<sup>210</sup> In Arizona, when a physician uses an investigational drug or procedure, he must inform his patient of its "novelty or its investigational status."<sup>211</sup> In both Arizona and New York, plaintiff must offer a physician's testimony to establish the professional standard or what a reasonable doctor would have disclosed in the situation.<sup>212</sup>

#### (iv) Disclosure and Frequency of Risk Occurrence

The Appellate Division's decision in *Marchione v. State*<sup>213</sup> represents the most recent significant case involving an allegation of a physician's failure to properly inform the patient. In *Marchione*, the plaintiff, a prison inmate, brought an action alleging lack of informed consent based on the failure of the prison doctor to inform him about the side effects of a hypertension drug, Minipress.<sup>214</sup> After taking the medication, the inmate suffered from permanent impotence.<sup>215</sup> The defendant-physician argued that at the date of the drug's administration, priapism, which led to the plaintiff's permanent impotence, was not a recognized side effect of Minipress.<sup>216</sup> The doctor further argued that, according to the medical literature, no causal link had been established between Minipress and priapism, and that the two or three cases reporting such causation in a population of several million did not create a significant risk of which the plaintiff had to be informed.<sup>217</sup> The doctor argued that his duty was only to inform patients of severe or frequent side effects.<sup>218</sup>

The *Marchione* case raises the question of when a significant risk exists and whether the determination of a physician's duty to inform is tied to the likelihood of that risk's occurrence. The

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by the profession's standards of due care. *Id.* at 785.

<sup>209</sup> *Retkwa*, 584 N.Y.S.2d at 711. The *Retkwa* court noted that the New York Legislature returned New York to the professional standard test in response to the threat of a physicians' strike in 1975. *Id.*

<sup>210</sup> *Id.* at 712.

<sup>211</sup> *Id.*

<sup>212</sup> *Id.* at 713.

<sup>213</sup> 598 N.Y.S.2d 592 (App. Div. 1993).

<sup>214</sup> *Id.* at 593.

<sup>215</sup> *Id.*

<sup>216</sup> *Id.* at 594.

<sup>217</sup> *Id.*

<sup>218</sup> *Id.* at 594.

Appellate Division upheld the trial court's determination that the physician's conduct was not unlawful and found that the risk was "so rare that it is entirely reasonable to not find a physician liable for failing to inform a patient of such a possibility."<sup>219</sup> The court accepted the argument that Minipress was limited in its potential danger to only two or three cases out of several million and therefore had too rare an incidence to require disclosure.<sup>220</sup> This decision, in effect, authorized the prison doctor's practice of telling patients only about the frequent side effects of the drug, despite the fact that the Physicians' Desk Reference (PDR), a manual that categorizes drugs currently available on the market, listed priapism as one of thirty-one reactions associated with Minipress.<sup>221</sup> The *Marchione* court concluded that a physician need not disclose a laundry list of reactions and side effects to the patient in order to comply with section 2805-d(1).<sup>222</sup>

In comparing the *Marchione* decision with the previously discussed *Nisenholtz* case,<sup>223</sup> a discrepancy in New York law regarding a physician's duty to disclose the low-percentage risks in a given procedure emerges.<sup>224</sup> In *Nisenholtz*, the risk of impotence resulting from surgery for ulcerative colitis was very remote and had a statistical rate of only one to two percent.<sup>225</sup> The defendants stipulated that a physician is required to indicate the likelihood of the occurrence of the risks, and in fact the physicians did discuss this slight risk with the plaintiff before surgery.<sup>226</sup> The court acknowledged that the risk, albeit very slight, was properly disclosed.<sup>227</sup> However, the court refused to rule as a matter of law that a physician's only duty is to list potential adverse reactions and their frequency of occurrence.<sup>228</sup> In certain situations where risks that are slight to the general population are more significant to the particular patient, the physician is required to provide more information, such as the mechanics by

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<sup>219</sup> *Id.*

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> *Id.* (holding doctor not liable for failing to list thirty-one remote side effects of Minipress).

<sup>223</sup> *Nisenholtz v. Mount Sinai Hosp.*, 483 N.Y.S.2d 568 (Sup. Ct. 1984).

<sup>224</sup> See *supra* notes 97-106 and accompanying text for an in-depth analysis of the *Nisenholtz* decision.

<sup>225</sup> *Nisenholtz*, 483 N.Y.S.2d at 569-70.

<sup>226</sup> *Id.* at 571.

<sup>227</sup> *Id.*

<sup>228</sup> *Id.* at 572.

which harm could occur.<sup>229</sup>

The decisions in *Nisenholtz* and *Marchione* are seemingly irreconcilable. In *Nisenholtz*, the doctor notified the patient of the existence of infrequently occurring side effects, namely the one or two percent risk of impotence.<sup>230</sup> Still, the court held the defendant-physician did not satisfy his duty because he did not provide the patient with enough information to make a "knowledgeable evaluation of whether to submit to that procedure."<sup>231</sup> The *Marchione* court did not even reach the question of whether the physician properly explained the risks because the court found that the physician did not have to disclose the slight risks.<sup>232</sup> The difference in analysis in the two cases cannot be attributed to the different risks involved since the risks did not really differ statistically. Perhaps the true distinction between the cases resides in the legal capacities of the plaintiffs. Mr. *Marchione* was a prison inmate, whereas Mr. *Nisenholtz* was an informed patient who was financially capable of contracting for the services of a private physician at a private institution. Short of unveiling such demarcations, fine tuning distinguishing features between the two cases remains difficult. Both *Marchione* and *Nisenholtz* involve infrequently occurring risks, and yet only the *Nisenholtz* court required disclosure of such risks, while the court in *Marchione* chose not to impose such a duty.

### C. Reasonable Person in Patient's Circumstances

The statute in section 2805-d(1) mandates that information be disclosed "in a manner permitting the patient to make a knowledgeable evaluation."<sup>233</sup> By reason of this language, the severity of the objective community medical standard—the practitioner under similar circumstances test—is mitigated by the statutory requirement that the physician ensure his disclosure is of a scope and caliber to allow the patient to make a knowledgeable evaluation. If plaintiff is able to show that a doctor's failure to disclose was not reasonable, section 2805-d(3) requires that plaintiff also establish that a "reasonably prudent person in the patient's position" would not have consented to the procedure or

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<sup>229</sup> *Id.* at 571.

<sup>230</sup> *Id.*

<sup>231</sup> *Id.*

<sup>232</sup> 598 N.Y.S.2d 592, 594 (App. Div. 1993).

<sup>233</sup> N.Y. PUB. HEALTH LAW § 2805-d(1).

treatment had he been fully informed.<sup>234</sup>

The statute marked a turning point away from case law that applied the "materiality to patient" standard enunciated in the landmark case *Canterbury v. Spence*.<sup>235</sup> In *Canterbury*, the complaint alleged that the doctor failed to obtain consent to a laminectomy procedure.<sup>236</sup> The court found that it was the physician's duty to provide that degree of information needed by the patient to form an intelligent decision.<sup>237</sup> The court concluded that the patient's right of self-determination shaped the parameters of the physician's duty of disclosure and set forth a "materiality" test for determining the risks that must be disclosed to the patient prior to evaluation and the patient's decision.<sup>238</sup>

This materiality to the patient test articulated by the United States Court of Appeals for the D.C. Circuit in *Canterbury*, was adopted in 1973 by the New York Appellate Division in *Fogal v. Genesee Hospital*.<sup>239</sup> Mrs. Fogal was injured through the use of a hypothermia blanket designed to cool her body temperature during kidney surgery.<sup>240</sup> The use of the blanket to induce hypothermia to slow the body's metabolism was a "recognized surgical practice" because the procedure required stopping the blood supply to portions of her body for long periods of time.<sup>241</sup> Because the electronic control unit designed to maintain the patient's body at a constant temperature was defective, Mrs. Fogal's feet, thighs and buttocks became necrotic, requiring removal of parts of her legs, buttocks, and both of her feet.<sup>242</sup>

The issue in *Fogal* was whether the doctor provided the patient with sufficient information regarding the risks associated

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<sup>234</sup> § 2805-d(3).

<sup>235</sup> 464 F.2d 772 (D.C. Cir. 1972).

<sup>236</sup> *Id.* at 778.

<sup>237</sup> *See id.* at 786.

<sup>238</sup> *See id.* at 786-87.

The scope of the physician's communication to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.

*Id.*

<sup>239</sup> 344 N.Y.S.2d 552 (App. Div. 1973).

<sup>240</sup> *See id.* at 556-57.

<sup>241</sup> *Id.* at 557.

<sup>242</sup> *See id.* at 556.

with the use of a hypothermia blanket.<sup>243</sup> The court specifically adopted the *Canterbury* rule, holding that a doctor has a duty to disclose to his patient those risks that will materially affect the patient's decision of whether to consent to the treatment.<sup>244</sup> Further, the court stated that the issue of whether the use of the hypothermia blanket was appropriate or necessary was immaterial because the critical issue was whether informed consent was obtained.<sup>245</sup> Given the likelihood that the patient's determination would be motivated by hindsight, the *Fogal* court asked whether a "reasonably prudent person in [the patient's] ... circumstances, having sufficient knowledge of the material risks incident to the procedure" would have undergone the surgery.<sup>246</sup> This was the standard applicable to all lack of informed consent cases in New York before the enactment of the 1975 statute.<sup>247</sup>

Under the Act, the patient's circumstances are considered by the court in determining whether the consent given was valid. Courts have indicated that an informed consent obtained from a patient during a time of extreme stress invalidates that consent.<sup>248</sup> Child birth has been identified as a time of extreme stress.<sup>249</sup> For instance, in *Hare v. Parsley*,<sup>250</sup> a physician's obtaining consent to perform an elective sterilization procedure during labor was invalidated.<sup>251</sup> Hence, the harshness of the objective standard of the medical community is mitigated by the requirement that a reasonable person in the patient's circumstances only agree to the procedure based on the information given "in a manner permitting the patient to make a knowledgeable evaluation."

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<sup>243</sup> *Id.* at 560.

<sup>244</sup> *Id.* at 559.

<sup>245</sup> *Id.* at 560.

<sup>246</sup> *Id.*

<sup>247</sup> See *id.*; see also *Barnette v. Potenza*, 359 N.Y.S.2d 432, 436 (Sup. Ct. 1974) (citing test enunciated in *Fogal* as correct test to be applied in medical malpractice informed consent cases); cf. Marjorie M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985) (discussing current status of informed consent doctrine).

<sup>248</sup> See *Hare v. Parsley*, 596 N.Y.S.2d 313, 315 (Sup. Ct. 1993) (holding as matter of law that physician and hospital deviated from accepted standards of medical care by accepting patient's consent for sterilization during childbirth).

<sup>249</sup> See *id.* at 314 ("[I]nformed consent may not be obtained while the patient ... is in labor or childbirth ....").

<sup>250</sup> 596 N.Y.S.2d 313 (Sup. Ct. 1993).

<sup>251</sup> *Id.* at 314.



### D. Role of Expert Testimony and Disclosure

Another aspect of the informed consent issue that has changed since the statute's enactment is the role of expert testimony.<sup>252</sup> Prior to the passage of the statute, courts, from their pro-patient posture, took the position that a patient's cause of action could be successfully established independent of expert testimony.<sup>253</sup> Courts chose not to look at the medical community's standard of practice in determining whether the patient had a right to sue for the physician's failure to obtain informed consent.<sup>254</sup> Instead, the courts adopted the *Canterbury* rule,<sup>255</sup> which regarded the medical standard as self-serving and required the guiding criterion for disclosure to be the materiality of the information to the patient.<sup>256</sup>

The case of *Zelevnik v. Jewish Chronic Disease Hospital*<sup>257</sup>

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<sup>252</sup> See N.Y. C.P.L.R. 4401-a (McKinney 1992). Section 4401-a provides that "[a] motion for judgment at the end of plaintiff's case must be granted as to any cause of action for medical malpractice based solely on lack of informed consent if the plaintiff has failed to adduce expert medical testimony in support of the alleged qualitative insufficiency of the consent." *Id.*; see also *Retkwa v. Orentreich*, 584 N.Y.S.2d 710, 711 (Sup. Ct. 1992) (explaining that "New York requires expert medical testimony to establish a prima facie case of lack of informed consent").

<sup>253</sup> See *Zelevnik v. Jewish Chronic Disease Hosp.*, 366 N.Y.S.2d 163, 171 (App. Div. 1975).

<sup>254</sup> See *Fogal v. Genesee Hosp.*, 344 N.Y.S.2d 552, 559 (App. Div. 1973) (stating that expert medical testimony should not be used to determine required level of disclosure).

<sup>255</sup> *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). In *Canterbury*, the court stated:

no basis [exists] for operation of the special medical standard where the physician's activity does not bring his medical knowledge and skills peculiarly into play.... The decision to unveil the patient's condition and the chances as to remediation ... is oftentimes a non-medical judgment and, if so, is a decision outside the ambit of the special standard. Where that is the situation, professional custom hardly furnishes the legal criterion for measuring the physician's responsibility to reasonably inform his patient of the options and the hazards as to treatment.

*Id.* at 785 (citations omitted). The court laid to rest the need for expert testimony in non-medical areas of judgment, namely, the scope of disclosure requirements. *Id.* Accordingly, it is submitted that this judicial effort circumvented the medical profession's "conspiracy of silence." Plaintiffs were able to establish a prima facie case without setting forth expert testimony as to what a reasonable physician would do under similar circumstances.

<sup>256</sup> *Garone v. Roberts' Tech. & Trade Sch., Inc.*, 366 N.Y.S.2d 129, 134 (App. Div. 1975) (adopting reasoning of *Canterbury* court by finding that "[t]he decision as to what is or is not material is a human judgment ... which does not necessarily require the assistance of the medical profession").

<sup>257</sup> 366 N.Y.S.2d 163 (App. Div. 1975).

went even further in disregarding the need for expert medical opinion when it held that such testimony is not only unnecessary but is also improper.<sup>258</sup> The court's rationale was predicated on the assumption that

[t]estimony of a specific medical community standard as to the risks to be divulged is necessarily permeated with self-interest in its attempt to state as concrete what is so nebulous.... The distractions of a battle between medical witnesses of the opposing parties as to an alleged community standard of disclosed risks have no place in a rational attempt to learn which risks, tested by general considerations of reasonable disclosure under all circumstances, should have been disclosed as materially affecting the patient's decision whether to proceed with the treatment.<sup>259</sup>

The *Zelevnik* court found that since the jury was in a better position to decide the issue of materiality of information, the jury was not bound by the conclusions of the medical community.<sup>260</sup>

In spite of this history of cases disregarding the need for expert testimony, the 1975 enactment of the medical malpractice statute re-introduced the requirement of expert medical opinion in support of a cause of action based on the failure to obtain informed consent.<sup>261</sup>

#### *E. Application of Statute and Retroactivity of Application*

Interesting issues arose in cases where alleged acts of medical malpractice occurred prior to the statutory mandate of 1975 but the degree of disclosure was challenged by the plaintiff-patient subsequent to that date. These cases typically involved a defendant's failure to obtain informed consent in factual situations that gave rise to questions of emerging trends in medical

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<sup>258</sup> *Id.* at 171.

<sup>259</sup> *Id.* at 170-71 (citations omitted).

<sup>260</sup> *Id.* at 170.

<sup>261</sup> N.Y. C.P.L.R. 4401-a (McKinney 1992). The statute states that the defendant is entitled to summary judgment at the close of the plaintiff's case if the plaintiff fails to produce "expert medical testimony in support of the alleged qualitative insufficiency of the consent." *Id.* For cases involving summary judgment under C.P.L.R. 4401-a, see *Hylick v. Halweil*, 492 N.Y.S.2d 57 (App. Div. 1985) (unnecessary surgery); *Lipsius v. White*, 458 N.Y.S.2d 928 (App. Div. 1983) (permanent damage to right hand and unnecessary surgery); and *Twitchell v. MacKay*, 434 N.Y.S.2d 516 (App. Div. 1980) (knee injury caused by physician manipulating knee).

practice.<sup>262</sup> For example, two such cases involved premature infants to whom prolonged oxygen was administered, resulting in a disease known as retrolental fibroplasia (RLF) and causing blindness.<sup>263</sup> Although questions were raised at the time as to the safety of liberal administration of oxygen, this medical practice continued.<sup>264</sup> In both cases, parental consent was not obtained for the placement of the premature infants in a higher than average oxygen environment.<sup>265</sup> In this manner, the issues of an acceptable standard of care and of the failure to obtain informed consent became intertwined.<sup>266</sup>

In *Burton v. Brooklyn Doctors Hospital*,<sup>267</sup> the court agreed that the issue of informed consent was inseparable from the malpractice question.<sup>268</sup> Further, the court asserted that the mere fact that the issue of informed consent was not presented to a New York court until 1965 did not relieve doctors of such duty prior to that date.<sup>269</sup> In fact, prior to the statutory mandate of 1975, doctors were certainly not free "to expose their patients to unwarranted risks without first obtaining their consent."<sup>270</sup> At all times, the requirement to obtain the patient's consent was a recognized responsibility of the physician.<sup>271</sup> Consequently, in *Burton*, the defendant-physician was legally mandated to explain the risks of treatment to the parents of the premature infant.<sup>272</sup> The general consent granted by the parents of the patient was

<sup>262</sup> See, e.g., *Kuncio v. Millard Fillmore Hosp.*, 499 N.Y.S.2d 525 (App. Div. 1986) (involving medical malpractice action by premature twins against hospital for failure to obtain informed consent from parents before administering high concentration of oxygen); *Flores v. Flushing Hosp. & Med. Ctr.*, 490 N.Y.S.2d 770 (App. Div. 1985); *Burton v. Brooklyn Doctors Hosp.*, 452 N.Y.S.2d 875 (App. Div. 1982).

<sup>263</sup> See, e.g., *Flores*, 490 N.Y.S.2d at 771; *Burton*, 452 N.Y.S.2d at 876.

<sup>264</sup> See *Burton*, 452 N.Y.S.2d at 877 (explaining that medical profession was divided as to whether practice should continue).

<sup>265</sup> See *Flores*, 490 N.Y.S.2d at 771; *Burton*, 452 N.Y.S.2d at 878.

<sup>266</sup> See *Flores*, 490 N.Y.S.2d at 772; *Burton*, 452 N.Y.S.2d at 880.

<sup>267</sup> 452 N.Y.S.2d 875 (App. Div. 1982).

<sup>268</sup> *Id.* at 880 ("In the factual context in which it is presented, the issue of informed consent is, to an extent, virtually inseparable from the malpractice question.").

<sup>269</sup> *Id.* at 881 ("Because a New York court was not squarely confronted with the issue until 1965 does not mean that the duty did not exist before then.").

<sup>270</sup> *Id.*

<sup>271</sup> In 1914, Judge Cardozo recognized this duty in *Schloendorff v. New York Hospital* by stating that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body ...." 211 N.Y. 125, 129 (1914).

<sup>272</sup> *Burton*, 452 N.Y.S.2d at 879.

inadequate because it simply authorized " 'the doctors ... to give such treatment and medication to [their] son which ... becomes necessary while he is a patient in the ... [h]ospital.' " <sup>273</sup>

The court found that the physicians could not protect themselves with the defense of acceptable medical practices because studies had indicated that increased oxygen was both unnecessary and dangerous. <sup>274</sup> This suggests that the defendants were required to inform parents not only of how they were planning to treat their child, but also on the then current controversy regarding oxygen treatment for premature infants. Hence, the parents should have been made aware of the emerging concerns regarding the use of oxygen and that their baby was being placed in a study concerning the effects of oxygen on RLF, which would require the infant to receive prolonged, high concentrations of oxygen. Also, even apart from the written consent, the parents should have been told of the risks involved and the options available before their baby was put into the experimental study.

The case of *Flores v. Flushing Hospital and Medical Center* <sup>275</sup> also involved the administration of oxygen to a premature infant which resulted in blindness. However, in *Flores*, the baby was not part of an experimental study, as was the case in *Burton*. In *Flores*, evidence was presented to show that without such continuous use of oxygen, the baby would have died or suffered brain damage. <sup>276</sup> Nevertheless, the parents of baby Flores were never informed about the risks of oxygen use and the possible consequence of blindness. <sup>277</sup> If they were informed of such risks, would the parents then have been reduced to choosing between death or blindness? This issue was ultimately irrelevant because the court remanded the case for a new trial on the grounds that the charge to the jury was too confusing and therefore mistaken as to the element of causation. <sup>278</sup>

#### *F. Relationship Between Statute and Common Law*

The New York judiciary has taken the position that the 1975 medical malpractice statute did not impose a new duty upon the

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<sup>273</sup> *Id.* at 880.

<sup>274</sup> *Id.*

<sup>275</sup> 490 N.Y.S.2d 770 (App. Div. 1985).

<sup>276</sup> *Id.* at 771.

<sup>277</sup> *Id.*

<sup>278</sup> *Id.* at 773.

doctor to disclose risks, diagnoses and treatment protocols and to obtain informed consent.<sup>279</sup> Instead, courts have found that the statute merely codified existing law and made changes in only some cases.<sup>280</sup>

(i) Nature of Cause of Action

In *Hughson v. St. Francis Hospital of Port Jervis*,<sup>281</sup> the issue was raised as to whom the cause of action for failure to obtain informed consent belonged: does the action involve the independent duty flowing between doctor and patient and therefore an independent claim for which the infant could seek redress and recovery for himself, or is the infant's action derivative of the mother's cause of action?<sup>282</sup> If the cause of action based on failure to obtain informed consent is an independent one, then the parent need not be a formal party to the action.<sup>283</sup> Conversely, if the cause of action is derivative of the parent's action, then that parent must be a formal party to the action on behalf of the infant for prenatal injuries arising out of the failure to obtain the parent's informed consent. The Appellate Division, Second Department, held that the infant's cause of action is viable and independent although the status of the child's incompetence to give binding consent to any medical services must be given through the parent.<sup>284</sup> Therefore, a minor can not be denied protection under section 2805-d.<sup>285</sup>

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<sup>279</sup> See *supra* note 267 and accompanying text; see also *Laskowitz v. Ciba Vision Corp.*, 632 N.Y.S.2d 845, 849 (App. Div. 1995) (stating that Public Health Law § 2805-d did not repeal common law doctrine of informed consent.).

<sup>280</sup> See *supra* note 148 and accompanying text.

<sup>281</sup> 459 N.Y.S.2d 814 (App. Div. 1983).

<sup>282</sup> *Id.* at 815.

<sup>283</sup> In *Woods v. Lancet*, the New York Court of Appeals recognized that a child may recover for injuries inflicted while the child was a viable fetus. 303 N.Y. 349, 357 (1951); see also *Kelly v. Gregory*, 125 N.Y.S.2d 696, 698 (1953) ("If the child born after an injury sustained at any period of his pre-natal life can prove the effect on him of the tort ... he makes out a right to recover.").

<sup>284</sup> *Hughson*, 459 N.Y.S.2d at 817.

<sup>285</sup> *Id.*

[S]ection 2805-d cannot be read to deny such minor or legally incompetent patients protection against incompetent advice or unauthorized treatment merely because they are not the persons from whom the law requires consent.... [I]t ignores the realities of modern obstetrical practice to deny the infant *in utero* independent protection against incompetent medical advice .... [I]t is absolutely vital that the cause of action belong to the infant, born alive, as well as [t]o the mother.... To deny an independent cause of action to the infant is to deny any recovery for direct physical injury, for the

## (ii) Comparative Negligence Defense

In *Bellier v. Bazan*,<sup>286</sup> the plaintiff brought an action for damages alleging that she had not been informed adequately of the risks of a breast reduction procedure, which caused her to sustain harsh discomfort in addition to severe and unnecessary scarring.<sup>287</sup> At the trial level, the jury found that her negligence contributed to the damages she sustained.<sup>288</sup> In concluding that plaintiff was comparatively at fault, the jury reduced her recoverable damages by fifteen percent.<sup>289</sup> The plaintiff appealed to set aside the jury's reduction of her damages on the grounds that "comparative fault [could not] be used as a defense in an action sounding in lack of informed consent."<sup>290</sup> She further argued that because the action for lack of an informed consent was statutorily circumscribed by the legislature, the only defenses available should be those codified in the statute itself.<sup>291</sup> The Appellate Division disagreed and found that actions in medical malpractice are like other actions in negligence, and therefore the doctrine of mitigation of damages is similarly available to actions for lack of informed consent as for other medical malpractice actions.<sup>292</sup>

## (iii) Admissibility of Habit Evidence

The cause of action based on a lack of informed consent is now firmly embedded in our judicial tradition as a negligence action.<sup>293</sup> Not surprisingly, the question of the admissibility of

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mother cannot recover in her own right for the infant's injuries.... The doctrine of informed consent may not be so rendered nugatory in pregnancy-related cases.

*Id.* at 817-18.

<sup>286</sup> 478 N.Y.S.2d 562 (Sup. Ct. 1984).

<sup>287</sup> *Id.* at 563.

<sup>288</sup> *Id.*

<sup>289</sup> *Id.* Comparative fault in the medical malpractice context has since been recognized in other New York cases. See, e.g., *Silvestri v. Smallberg*, 637 N.Y.S.2d 115 (App. Div. 1996) (recognizing the possibility of reduction in amount of jury award, but noting there was insufficient evidence of plaintiff's negligence).

<sup>290</sup> *Bellier*, 478 N.Y.S.2d at 564.

<sup>291</sup> *Id.*

<sup>292</sup> *Id.* ("Although lack of informed consent is a distinct cause of action which should be separately pleaded in the complaint, it remains a form of medical malpractice where liability is determined by the standard of a 'reasonable medical practitioner.'") (citations omitted).

<sup>293</sup> See *Dries v. Gregor*, 424 N.Y.S.2d 561, 564 (App. Div. 1980) (stating that conduct of parties should be examined under negligence analysis).

habit evidence in a cause of action for informed consent has been raised. In *Rigie v. Goldman*,<sup>294</sup> the plaintiff was advised by her doctors to have an impacted wisdom tooth removed, and she agreed.<sup>295</sup> As a result of the surgery, the plaintiff suffered from a permanent condition known as paresthesia—a numbness of the lip, chin or tongue, which is caused by injury to a nerve within the oral cavity.<sup>296</sup>

The defendant, who specialized in oral and maxillofacial surgery, and his dental assistant were permitted to testify as to the dentist's routine practice, which had developed over nineteen years.<sup>297</sup> According to the defendant, that habitual routine included telling patients about the risks and complications of wisdom tooth extraction, as well as warnings that no alternative to extraction existed.<sup>298</sup> The doctor's dental assistant confirmed his testimony and stated that she had witnessed hundreds of such surgical procedures that were performed exactly the way the defendant-dentist had described them.<sup>299</sup> The Appellate Division permitted the admission of such habit evidence as circumstantial evidence.<sup>300</sup> The court followed the New York Court of Appeals decision in *Halloran v. Virginia Chemicals*,<sup>301</sup> which was the first case in which the Court of Appeals allowed habit evidence of repetitive conduct in personal injury actions.<sup>302</sup> In the opinion of the *Rigie* court, a medical malpractice action was like any other negligence action. According to the court, the habit evidence at issue must be examined and where the evidence of habit "exhibits a uniformity of response and a sufficient number of instances of the repetitive conduct, it is admissible."<sup>303</sup>

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<sup>294</sup> 543 N.Y.S.2d 983 (App. Div. 1989).

<sup>295</sup> *Id.* at 983.

<sup>296</sup> *Id.* at 984.

<sup>297</sup> *Id.*

<sup>298</sup> *Id.*

<sup>299</sup> *Id.*

<sup>300</sup> *Id.* (noting that general rule allows evidence of habitual behavior as circumstantial evidence).

<sup>301</sup> 41 N.Y.2d 386 (1977).

<sup>302</sup> Until *Halloran v. Virginia Chemicals*, the general rule in New York was that habitual conduct was inadmissible when offered in a negligence case to raise an inference of the exercise of the same amount of apparent caution or incaution on the occasion in question. RICHARD T. FARRELL, PRINCE, RICHARDSON ON EVIDENCE (11th ed. 1995).

<sup>303</sup> *Rigie*, 543 N.Y.S.2d at 986-87.

#### IV. CONCLUSION

The New York statute, which was enacted twenty years ago in a climate of uncertainty, has received careful evaluation and fairly consistent judicial interpretation. At this juncture, the case law uniformly deems a cause of action for the failure to obtain informed consent to be an action in negligence. A successful medical malpractice action today must be supported by expert medical testimony.

The statute has imposed on the New York medical community the twin duties of providing the patient with that degree of information that furthers the patient's right to self-determination, as well as the duty to obtain the patient's informed consent. The requirements for providing disclosure and for obtaining the patient's consent are enunciated in the statute. The statute mandates an objective test that both the provider and the patient must meet. Each party's role in executing his respective mandate, as defined by the statute, is determined by comparing the acts of the party with what the reasonably prudent person would do in similar circumstances. Nonetheless, the statute infuses an element of subjectivity with regard to the patient's informational needs and concedes that an appropriate evaluation by the patient can occur only when that particular patient's unique requests have been met.

The jurisprudence has evolved to require the duty to obtain consent only from the provider who furnishes the treatment. Any other provider in the medical hierarchy is not burdened by the statutory requirements unless he participates in the course of treatment. The case law interpretation of the "foreseeable risks" that must be revealed by provider to patient has been uneven. The case law is uniform in its requirement that the provider's mandate be pro-active and not merely reactive. The provider's role is more than merely an educational one since it is through the provider's digesting of technical material that the patient becomes empowered to make an appropriate evaluation of his course of treatment. To sit back and answer an occasional query of the patient will not satisfy the requirements of the legislation.

To the extent that certain risks occur only infrequently, the case law is divided. Some cases require disclosure of those risks that occur at a one percent frequency while other cases suggest that a risk that occurs in only two or three cases in a million



need not be revealed.

Similarly, the case law is uniform in its analysis of disclosure requirements pertinent to those areas of medicine that evince the quality of emerging medical trends and standards of practice. The medical community defines the test for disclosure. Where that standard cannot be discerned, the disclosure to the patient need not be individualized, but it may instead be determined by that to which the reasonably prudent person in similar circumstances would have agreed.

In conclusion, the last two decades since the passage of the medical malpractice statute have marked a critical period for judicial analysis and interpretation of the statutory provisions. The case law has since evolved into a body of law with fairly uniform markers for the practicing health care professional.